

FROM MEDICAL RELIEF TO COMMUNITY HEALTH CARE

**A CASE STUDY OF A NON-GOVERNMENTAL ORGANISATION
(FRONTIER PRIMARY HEALTH CARE)
IN NORTH WEST FRONTIER PROVINCE, PAKISTAN**

Margaret Madeline Patterson

**Ph.D.
School of Social and Political Studies
The University of Edinburgh
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From MEDICAL RELIEF to COMMUNITY HEALTH CARE:

A case study of a non-governmental organisation (NGO) in North West Frontier Province, Pakistan

This case study is designed to answer the question whether refugees can make a positive contribution to host countries, not simply as individual participants in economic activity, but by contributing to welfare. The thesis provides a detailed study of an NGO originally established to provide medical relief for refugees but which now provides basic health care for local people. Since 1995 this NGO has adopted a policy of providing the same basic care to refugees and to people in local Pakistani villages, thus making no distinction between refugees and the residents of a specific geographical area. The case study also shows that an NGO can be an appropriate and effective provider of primary health care (PHC) as promoted by the 1978 Declaration of Alma Ata.

The thesis uses several approaches to demonstrate why this happened and how it was achieved. Firstly, it narrates the history over the twenty-year period 1980-2000 of an international health project originally started for a group of Afghan refugees, and its transformation in 1995 into an indigenous Pakistani NGO called "Frontier Primary Health Care (FPHC)". Secondly, the study explores the theoretical utility and limitations of the PHC strategy generally. Thirdly, the thesis provides an analysis of the extent to which the underlying principles or "pillars" of PHC, that is, participation, inter-sectoral collaboration and equity have affected the process and outcomes of the project.

Locating the case study in the Pakistani context provides evidence of the persistent difficulties and shortcomings of official government basic health care in Pakistan, particularly for rural poor people, showing that the field is open for other providers of health care, such as NGOs. The thesis goes on to discuss strengths and weaknesses of NGOs in general, and particularly as health care providers. In investigating characteristics of the NGO sector in Pakistan, the study pays special attention to the discrete health care system for Afghan refugees created in the early 1980s, including its introduction of Community Health Workers.

In order to assess the impact of the NGO on people's health, the study uses data from mother/child health and family planning programmes (as far as available) demonstrating that this NGO is a more effective provider than the other two agencies i.e. the Government of Pakistan and the Afghan Refugee Health Programme. Placing the NGO in this context also shows that it has a better understanding of the underlying "pillars" and has made more determined and effective efforts to implement them, especially in regard to community involvement.

It is unusual for a project initially refugee-oriented to have matured sufficiently to be making a contribution, as a matter of formal policy, to basic welfare in the host country, itself a developing country. The study concludes that the significant factors in its success are continuity of leadership; boundaries of population, geography and administration; dependable income and material resources; rigorous supervision; support, but not takeover, by experienced consultants; capacity to use learning to adapt and move on; and sensitivity to local cultural norms. All these have enabled the project to survive and develop as an indigenous autonomous organisation beyond the twenty years covered by the case study. FPHC is still operational in 2004.

Declaration

This is to certify that this thesis “From Medical Relief to Community Health Care” has been composed by me, is all my own work and has not been submitted for any other degree or professional qualification at this or any other University.

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<i>Ch 5 (contd)</i>	<i>analysing NGOs and their development</i> <i>stages of growth & development</i> <i>advantages and disadvantages</i> <i>the NGO scene in Pakistan: legislation, reality</i> <i>distribution, size, interests, environment, typology</i> <i>a discrete category of NGOs in Pakistan</i> <i>health-oriented NGOs working with refugees</i> <i>two discrete health services in NWFP</i> <i>NGOs and the Government of Pakistan</i> <i>change in attitudes: GOP as donor and an in-country donor</i> <i>NGOs and donors: "projectitis"</i> <i>projectitis and donors</i> <i>NGOs and discrimination</i> <i>the problem of survival</i>	
Chapter 6	Three Pillars of PHC: the first pillar: participation 139 <i>the three pillars</i> <i>implementing participation— an additional consideration: leadership</i> <i>three services: common features</i> <i>defining community participation: the Afghan refugees</i> <i>the non-refugee community</i> <i>analysing community participation—Rifkin's model</i> <i>participation analysis—five levels</i> <i>an alternative analysis of participation offered at FPHC</i> <i>leadership for primary health care—arguments for training</i> <i>leadership at ARC/PHC/FPHC</i> <i>leadership, dedication and motivation</i> <i>summary based on Rifkin's five levels of participation</i>	
Chapter 7	The Second Pillar: Inter-sectoral Collaboration 177 <i>types of inter-sectoral collaboration</i> <i>in NWFP—a "de facto" additional sector</i> <i>locating ARC/PHC/FPHC—which sector?</i> <i>ARC/PHC/FPHC: inter-sectoral collaboration and developmental phases</i> <i>within the ARC health project itself—inter-sectorally</i> <i>the 1995 watershed: FPHC and inter-sectoral collaboration</i> <i>donors as collaborators</i> <i>a new donor introduces a new technique</i> <i>limitations on inter-sectoral collaboration by FPHC</i> <i>community initiatives in inter-sectoral collaboration</i> <i>a missed opportunity for inter-sectoral collaboration</i> <i>understanding and implementing inter-sectoral collaboration</i> <i>collaboration: effects on FPHC as an organisation</i>	
Chapter 8	The Third Pillar: Equity—and Efficiency 203 <i>equity—the global picture updated</i> <i>efficiency in health care delivery</i> <i>Pakistan: geographic, socio-economic and other inequalities; corruption</i> <i>NWFP—a special case within Pakistan: two population groups—health care</i> <i>in Afghanistan; the Refugee Health Programme</i>	

<i>Ch 8 (contd)</i>	<i>ARC/PHC and equity</i> <i>FPHC and equity</i> <i>equity and efficiency at FPHC</i> <i>Nabarro and Cassels' "universal problems of management"</i> <i>charging for primary health care</i> <i>donors and equity</i>	
Chapter 9	FPHC's Impact on Health.....	235
	SECTION A: <i>qualitative data–Ajmal's framework</i> <i>ARC/PHC/FPHC and Ajmal's stages of impact</i>	
	SECTION B: <i>quantitative data–justification for limitation to MCH data</i> <i>disadvantages of choosing MCH data</i> <i>some cautions about routine data generally</i> <i>data in Pakistan: specific problems</i> <i>Afghan refugee data, including health</i> <i>quantitative data at ARC/PHC/FPHC: results</i> <i>infant mortality and under-five mortality rates</i> <i>other MCH data at ARC/PHC/FPHC</i> <i>comment on MCH data at ARC/PHC/FPHC</i>	
	SECTION C: <i>family planning–qualitative and quantitative data</i> <i>special considerations in NWFP</i> <i>policy and practicalities</i> <i>family planning and the refugee population</i> <i>family planning: quantitative data at ARC/PHC/FPHC</i>	
Chapter 10	Conclusions and lessons learned	276
	<i>health care in NWFP–some clarifications</i> <i>the research questions</i> <i>has the research met the aim of the case study?</i> <i>influential factors</i> <i>lessons learned</i> <i>wider ramifications</i> <i>limitations and questions</i>	
Photographs between chapters 5 and 6		
	<i>Inside a refugee camp.....</i>	<i>135</i>
	<i>Inside a Pakistani village</i>	
	<i>Gandaf camp Health Centre.....</i>	<i>136</i>
	<i>Wardaga village Health Centre</i>	
	<i>Girls' class at Baghicha camp.....</i>	<i>137</i>
	<i>Girls growing into women</i>	
	<i>Lady Health Visitor monitoring child weight</i>	<i>138</i>
	<i>Back from Afghanistan–treating a mine injury</i>	
	<i>Treating children in a tent during repairs to Gandaf Health Centre...</i>	<i>139</i>
	<i>Camp residents repairing roof at Gandaf Health Centre</i>	

Annexes	
1 . <i>The volunteer couple</i>	296
2. <i>List of interviewees</i>	299
3. <i>Samples of interview prompts</i>	301
4. <i>Five research questions: five charts</i>	311
5. <i>FPHC after year 2000</i>	316
Bibliography	323

Tables, Charts and Figures

Tables

Chapter 3	Table 3.1	<i>Charitable agencies providing health care for Afghan refugees in 1980</i>
	Table 3.2	<i>ARC health staff turnover 1980-1986</i>
Chapter 5	Table 5.1	<i>Strategies of development-oriented NGOs: four generations</i>
	Table 5.2	<i>Charitable agencies recognised by Pakistani authorities for providing health care for the Afghans in 1984</i>
	Table 5.3	<i>Organisations providing health care for Afghans from NWFP, 1989</i>
	Table 5.4	<i>Implementing Partners (charitable agencies) providing services including health to Afghan refugees 2001</i>
Chapter 6	Table 6.1	<i>PHC components by group</i>
	Table 6.2	<i>Staff complement at field units of 3 services</i>
	Table 6.3	<i>Numbers of patients attending on one day</i>
Chapter 9	Table 9.1	<i>ARC/PHC survey of villages of Zando, Rashaka, Kagan 1994</i>
	Table 9.2	<i>IMR and Under-5 MR, ARC/PHC/FPHC</i>
	Table 9.3	<i>IMR (Infant Mortality Rate) FPHC, NWFP and Pakistan</i>
	Table 9.4	<i>Under 5 Mortality Rate FPHC, NWFP and Pakistan</i>
	Table 9.5	<i>Percentage of antenatal cover FPHC, NWFP and Pakistan</i>
	Table 9.6	<i>Percentage of supervised deliveries FPHC, NWFP and Pakistan</i>
	Table 9.7	<i>Percentage of postnatal cover (home visit by trained staff)–FPHC, NWFP and Pakistan</i>
	Table 9.8	<i>Low birth weight babies FPHC, NWFP and Pakistan</i>
	Table 9.9	<i>Children immunised FPHC, NWFP and Pakistan</i>
	Table 9.10	<i>Pakistan population numbers/contraceptive prevalence rate</i>

Charts

Chapter 3	Chart C3.1	<i>ARC/PHC Structure</i>
	Chart C3.2	<i>PHC Programme: organisation of activities</i>
	Chart C3.3	<i>ARC/PHC staff numbers and nationality 1980-2000</i>
	Chart C3.4	<i>ARC/PHC and FPHC annual expenditure 1980-2000</i>
Chapter 9	Chart C9.1	<i>Number of women in family planning programme at ARC/PHC/FPHC</i>

Figures

Chapter 3	Figure F3.1	<i>Map of provinces of Pakistan</i>
	Figure F3.2	<i>Pakistan-Afganistan, refugee locations</i>
	Figure F3.3	<i>Extract from FPHC's Memorandum of Association 1995</i>
	Figure F3.4	<i>Diagram of FPHC Health Centres in 2001</i>
Chapter 6	Figure F6.1	<i>Role of volunteer community health worker (male)</i>
	Figure F6.2	<i>Role of female health worker</i>
Chapter 9	Figure F9.1	<i>Samples of ARC health records 1980,1990</i>

Acronyms and abbreviations

ACBAR	Agency Co-ordinating Body for Afghan Refugees
a d c Austria	Austrian Association for Development and Co-operation
AR	Annual Report
ARHP	Afghan Refugee Health Programme
ARC	Austrian Relief Committee for Afghans
ARIC	Afghan Resource and Information Centre
ARC/PHC	Austrian Relief Committee Primary Health Care Project
AS	Austrian Schillings
BCG	Bacillus Calmette-Guérin
BHU	Basic Health Unit
BOND	British Overseas NGOs for Development
CAR	Commissioner for Afghan Refugees
CBO	Community Based Organisation
CDC	Center for Disease Control
CIDA	Canadian International Development Agency
CHS	Community Health Supervisor
CHW	Community Health Worker (male)
CPHC	Comprehensive Primary Health Care
CYNGOs	In-Country NGOs
DfID	Department for International Development
DHO	District Health Officer
DPT	Diphtheria, Pertussis, Tetanus
DT	Diphtheria, Tetanus
EDO	Executive District Officer (Health)
EPI	Extended Programme of Immunisation
FHW	Female Health Worker
FMT	Female Medical Technician
FP	Family Planning
FPAP	Family Planning Association of Pakistan
FPHC	Frontier Primary Health Care
GDP	Gross Domestic Product
GOP	Government of Pakistan
HC	Health Centre
HDR	Human Development Report
HRD	Human Resources Development
ICD	Italian Co-operation for Development
IIZ	Institut Internationale für Zusammenarbeit
INGO	International NGO
IRC	International Rescue Committee
IRIN	Integrated Regional Information Network
ISEqH	International Society for Equity in Health
JFS	Joint Funding Scheme
LHV	Lady Health Visitor
LHW	Lady Health Worker (Benazir Bhutto's Scheme)
MCH	Mother and Child Health
MD	Managing Director
MICS	Multiple Indicators Cluster Survey
MMT	Male Medical Technician
MO	Medical Officer
MSF	Médecins sans Frontières

NHS	National Health Service (UK)
NGO	Non-Governmental Organisation
NWFP	North West Frontier Province
OPD	Out Patient Department
OPV	Oral Polio Vaccine
ORS/ORT	Oral Rehydration Solution/Oral Rehydration Therapy
Pak-CDP	Pak-Community Development Project (<i>sic</i>)
P and D	Planning and Development
PDH	Project Director Health (of the ARHP)
PHC	Primary Health Care
PIHS	Pakistan Integrated Household Survey
PRA	Participatory Rural Appraisal
RDP	Rural Development Programme
Rs	Pakistani Rupees
SAP/PDP	Social Action Project/Participatory Development Programme
SBH	Sanitation and Basic health
SCF	Save the Children
SPDC	Social Policy and Development Centre
SPHC	Selective Primary Health Care
TAF	The Asia Foundation
TB	Tuberculosis
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
TVO	Trust for Voluntary Organisations
UK	United Kingdom
UNDP	United Nations Development Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
US	United States
VSO	Voluntary Service Overseas
WAPDA	Water and Power Development Authority
WDP	World Development Programme
WDR	World Development Report
WFP	World Food Programme
WHO	World Health Organisation

CHAPTER 1

INTRODUCTION: JUSTIFICATION, AIMS AND OBJECTIVES

Introduction: refugees, poverty and health

In 1986, in her preface to “Imposing Aid”, Barbara Harrell-Bond said

“Refugees are one of the most serious problems of our times. Daily the numbers escalate”

She did not quote figures, but by the late 1990s, estimates were around 53 million people worldwide: 30 million internally displaced and 23 million seeking refuge across international borders (Reed, Haaga and Keely 1998, quoted by Banatvala and Zwi, 2000: 101). More recently, in 2004, the United Nations High Commission for Refugees (UNHCR) issued figures showing a considerable reduction: refugees and displaced people around the world had fallen to just over 17 million. Ruud Lubbers, the UN High Commissioner for Refugees, declared the statistics to be very encouraging. But the same news item noted that conflict in Sudan’s Darfur region is creating a new refugee crisis (BBC News 17.06.04). Nearly twenty years after Harrell-Bond’s assertion, refugees are a recurring problem in today’s world.

In contrast to the post-World War II refugee crisis in Europe which stimulated the creation of UNHCR, the mass movement of Afghans into Pakistan typifies many later and contemporaneous refugee situations (Gorman 1993: 2; Hartling 1984, quoted by Callamard 1993: 129). Most of the Afghan refugees who came into Pakistan from 1980 onwards, the great majority into the North West Frontier Province (NWFP), were rural poor people, similar to the local population. The Afghans had fled a poor country in the developing world into another with serious problems of under-development.

“Severe poverty, in other words, seems to be closely associated with the refugee phenomenon” (Gorman 1993: 4)

In developing countries, poverty is likely to be significant at national level, where income (e.g. from taxes) may be inadequate to fund services, or available income may be inappropriately allocated (e.g. on arms and defence); or the country may be saddled with large debt repayments on external loans. Poverty is also significant at grassroots level, but it

is not merely a matter of inadequate income: it is a complex notion with many aspects. The “poverty line” concept of income below a minimum standard is of limited use, because it begs the question of what is a minimum standard, and also the question of comparability between societies. Poverty is relative: what is nowadays considered poverty in western industrialised “developed” countries does not condemn huge numbers of people to the extreme level of disadvantage and deprivation of millions of people in the developing world.

In developing countries, the quality of life of the poor, who constitute the majority of the population, is likely to be seriously affected not only by low income, but by high birth-rate and rapid population increase, poor housing both urban and rural, lack of infrastructures and inadequate basic services. Scarcity of job opportunities and/or access to land mean that families cannot afford to pay for sufficient nourishment, or access to health care, or other basic needs, leading to increased health problems. Mothers (and therefore infants) lack proper care during child-bearing years, people (especially children) become more exposed to health risks, including susceptibility to infections, which tend to be more virulent in malnourished people. Health—or rather ill-health—in these countries is therefore intimately connected with the many facets of poverty:

“It is a commonplace to say that poverty and ill-health are mutually reinforcing” (Eade 1997: 5)

Mass flight from one under-developed country to another with loss of homes, land or jobs aggravates grassroots poverty, so that

“Refugees who have crossed international borders are among the poorest and most powerless people in the world” (Chambers 1983: 39-40)

While it is not true that all refugees are poor, those few with resources will try to move themselves and their immediate families to western countries. The vast majority of refugees are obliged to remain in the developing country of first reception, comprising large populations of poor people: hence the common perception that they constitute an additional burden on host countries. The UNHCR 2004 statistics claim that more than half a million refugees returned to Afghanistan in 2003, but they also show that Afghans remained the largest single group of refugees in the world, with 2.1 million people looking for refuge in 74 countries. Pakistan remains the top country for asylum, hosting 1.1 million refugees and asylum seekers, most of these being Afghans (BBC News 17.06.04)

The multi-faceted nature of poverty has close links with ill-health. Townsend and Davidson made this explicit in their influential study of inequalities in health in the UK. The post-war development of globalisation has reinforced the realisation that there are health discrepancies

within and between countries, closely associated with poverty. Health is therefore an important indicator for measuring quality of life, which itself is multi-dimensional. WHO's celebrated definition of health as

"a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (Declaration of Alma Ata 1978)

is a positive one, and its slogan "Health for All by the Year 2000" upholds health as a universal right, showing a concern for social justice and social inclusion.

Poverty at grassroots level is socially exclusive, because its associated practical pre-occupations and disadvantages reduce people's capacity to participate in economic, social and political life. Drèze and Sen develop this socially-focussed perception of poverty:

"Poverty lies not merely in the impoverished state in which the person actually lives, but also in the lack of real opportunity—given by social constraints as well as personal circumstances—to choose other types of living. It is ultimately a matter of 'capability deprivation' " (2002: 35/36)

They regard this as a foundational view of poverty, linked with the deprivation of such basic capabilities as literacy and expectation of life, which affect life choices and ultimately, in their view, freedom. Gazdar, reviewing poverty in Pakistan, converts Drèze and Sen's broad ideology into a practical approach:

"Issues such as the advancement of basic education, the provision of public health, and the protection of legal, civil and political rights all need to be addressed as integral parts of any anti-poverty agenda" (1999: 315)

Refugees being recognised as belonging to the world's poorest, and Afghans in Pakistan being more numerous and displaced for longer than almost any other refugee group, their needs and disadvantages across the board are on the grand scale. Their "*capability deprivation*" must be considerable.

That is a blanket view of the refugees. This case study argues that it has been possible for one NGO, mostly staffed by refugees, not only to be involved with improving an aspect of their lives closely associated with poverty, that is, health and health care, but to become capable of sharing its achievement for the benefit of a another group of poor people, those belonging to the host country.

Justification for the case study

This case study follows from my (MMP) involvement (1991-1998), and that of my husband (JSP), with the NGO now known as “Frontier Primary Health Care” (FPHC), based in Pakistan’s North West Frontier Province.

The NGO has a stated aim of practising primary health care (PHC). As the Austrian Relief Committee for Afghan Refugees (ARC), the organisation was originally started to provide medical relief to a group of approximately 30,000 Afghans in three of the many refugee camps, a fraction of the eventual total of 3.5 million Afghans who moved into Pakistan as a consequence of the Soviet invasion of their country in 1979. Voluntary Service Overseas (VSO), a British organisation committed to the reduction of poverty in the developing world, placed us in this health project for the usual two-year allocation period in 1991. MMP was the Administrator, JSP the accompanying spouse. He later became the Medical Adviser. The VSO placement finished in 1993, but we remained involved with the NGO for much longer. This was because of policy change in the donor agency, and changes in the NGO itself. From 1994 onwards our roles were different. The Austrian Association for Development and Co-operation (a d c Austria), the donor agency, engaged me (MMP) to act as Development Adviser; JSP worked in a similar capacity but on a voluntary basis. This commitment ended in 1998.¹

Our prolonged experience in NWFP fostered the idea of critical academic study of an NGO having a stated aim of providing basic health care to rural poor people. From its original purpose in 1980 of providing medical relief to a specific group of refugees the health project claimed to have developed its work during the 1980s along Primary Health Care (PHC) lines. In the mid-1990s a plan emerged to extend the work to local Pakistani villagers, while continuing service to the original refugee group. Chapter 3 on the history of the NGO recounts these developments in detail.

I believe this case study is further justified on the following grounds:

1. There appears to be a **need for more Pakistan-related research**. Gazdar, embarking on a review of the study of poverty in Pakistan states that the country is relatively under-researched. He agrees that the traditional concentration on the economic aspect of poverty is too narrow, since it omits the wider issues of health and education. He notes that Pakistan unlike India does not publish official regular data on poverty lines and poverty indices. Even if definitions of these indicators are variable, information of this

¹ See Annex 1 for outlines of our respective backgrounds, our changing roles in the NGO from 1991-1998, and some challenges of undertaking a case study in which our personal involvement was so considerable.

kind would have implications for education and health (1999: 241). Additionally, in discussing rural poverty, Gazdar makes the specific point that relatively little work on regional patterns of poverty has been done (1999: 243). He himself restricts the more detailed part of his discourse to the Provinces of Punjab and Sindh, with no mention of NWFP, where FPHC is located.

2. There is a **lack of formal evaluation of PHC initiatives**. Although there is a rich literature on PHC as a health care strategy, including efforts to implement it at national level in several countries, there seem to be few case studies of attempts to introduce and sustain it by agencies other than the state. Banatvala and Zwi in discussing public health (with specific reference to refugees) argue for the development of an evidence base for humanitarian interventions in such situations:

"Current debates regarding evidence-based medicine and evidence-based policy have permeated all spheres of health care...In addition to evidence of effectiveness and efficiency, evidence related to other dimensions of health interventions, such as their humanity, equity, local ownership and political and financial feasibility is important". (2000:101).

Their citing of poor quality health care delivery by NGOs in Rwanda does not invalidate their argument for disseminating and generalising from what they describe as *"the vast and valuable foundation of field experience"*, for lessons can be learned from material displaying features apparently negative as well as those considered positive. A detailed case study of one public-health-oriented NGO is a means of presenting such material.

3. There seems to be a **need for more research on NGOs in Pakistan, and also on health-oriented NGOs**. Sims (1997: 204) notes the lack of research on NGOs in Pakistan. Key (1990: 71) stresses the difficulty of obtaining even basic contact information. Both Key and Sims add that data they managed to obtain were urban-biased. Practical problems of communication, transport, and risk to personal safety in more remote areas imposed limitations on research. Green and Matthias note the scarcity of writing on NGOs operating in the health sector in developing countries (2000: x)
4. **Frontier Primary Health Care is an NGO still operational 24 years after its foundation in 1980**. Instability of Pakistan's internal politics, fluctuations in international relationships over this prolonged period and repercussions on Pakistan have affected the activities of many NGOs, especially those concerned with refugees. Bearing in mind also the financial problems to which NGOs as a category are prone, the survival of this NGO lends itself to a longitudinal study.

Aims and objectives of the case study

Overall aim:

To assess whether, and if so to describe and analyse the process by which, a health-oriented NGO has moved from refugee medical relief to the provision of non-discriminatory primary health care for residents of a specific area i.e. those belonging to the host country as well as refugees, from its inception in 1980 until 2000.

Objectives

1. To trace the evolution of the NGO Frontier Primary Health Care (FPHC) from 1980-2000, including relationships with donors, with other agencies and with the Government of Pakistan.
2. To contextualise the NGO "Frontier Primary Health Care":
 - by accounting for the emergence of primary health care (PHC) as a concept, and the relevance of WHO's recommended policy and practice of PHC in the developing world
 - by assessing the effectiveness/limitations of NGOs as health providers in the developing world, particularly with regard to primary health care in Pakistan
 - by comparing and contrasting the NGO FPHC, where possible, with other locally available basic health care services for refugees and non-refugees: programmes, staffing, resources and impact, particularly on services for women and children/family planning
 - by using Macdonald's "Three Pillars" (1998: 84) of PHC (participation, inter-sectoral collaboration and equity) to assess how far FPHC and other existing basic health care services in NWFP implement these.
3. To identify social and cultural factors which have influenced either positively or negatively the development of FPHC
4. To draw conclusions from the research and identify lessons learned of potential interest to academics and practitioners in the field of basic health care in the developing world.

Chapter 2 outlines the design and methods used in pursuit of the overall aim of the case study. Chapter 3 recounts the history of FPHC and its immediate predecessor from its beginnings in 1980 until 2000. Chapter 4 traces the origins of the Primary Health Care ideology and practical strategy, and its relevance to the developing world. Chapter 5 assesses

NGOs as health care providers, especially within Pakistan. Chapters 6, 7 and 8 use Macdonald's "Three Pillars" of primary health care as the framework for a detailed discussion of FPHC, with reference to the other basic health care services available to refugees and non-refugee local people. Chapter 9 attempts to assess the impact of two of FPHC's programmes, both affecting mothers and children: mother and child health and family planning, with reference also to the other services. Chapter 10 draws together conclusions from the research and seeks to identify lessons learned. Most chapters include allusions to the distinctive Pathan culture shared by the Afghan refugees and the local Pakistani population of the area in which FPHC operates.

I begin with issues of research design and data collection.

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CHAPTER 2

DESIGN AND METHODS

This chapter explains how I approached the case study of FPHC in terms of general preparation, choice of method, and construction of a formal research design. The chapter includes the five questions which provided a framework for the research, and notes on the design plan and sources of data. It explains emergent themes, modifications and alterations, and also constraints and problems encountered during the research.

Approaching the research task

Change of role

The focus of my work during seven years of intimate involvement with the NGO was a restricted one. Tasks were largely office-based, working with staff and donors. Work did not require direct contact with patients. I did not need to know much about the official health care system for the majority of the Afghan refugee population in Pakistan. I knew the GOP's system of basic care for its own nationals mostly by reputation, though I had visited two or three government Basic Health Units (BHUs) in the mid-90s.

I had some experience of the implications of role-change—sometimes within the same organisation—in my professional life in Scotland 1968-1991 as social worker, volunteer, counsellor, team manager, minute-taker, committee member. As researcher into aspects of social work practice, I had learned to distance myself in group situations and withhold my opinion when staff who knew me well would have liked one. In NWFP, I had already changed role from Administrator/Project Manager (1991-93) to Development Adviser (1994-98). This last required research into legislation, drafting formal documents and writing proposals; much of it was done in the UK. Although it carried no decision-making responsibility nor immediate connection with current practice, it still required commitment to the organisation.

To counteract the specificity of earlier non-research remits at FPHC, as a researcher I needed to learn more about the context in which the NGO was located. Acquiring this new overview perspective would help to reduce closeness to the NGO, and also throw the NGO into relief by enabling some comparison with other health care agencies in NWFP. However, my

knowledge of the NGO absorbed since 1991 outstripped what I could discover about the others in the time available for fieldwork. I recognised that the long-term intimacy with the NGO could endanger impartiality required for research. Intimacy might affect my capacity to “hear” the meaning of primary data gathered in interviews. As a result I might not access criticisms, a lack which could lead to overdue credence and ultimately affect analysis. The inevitable discrepancy between primary data from the NGO and from other health care agencies had other bias potential: there was a risk that data from the other agencies would be no more than impressionistic.

Dealing with bias

Patton (2002: 574-576) discusses the relationship of bias with the apparently contrasting concepts of objectivity and subjectivity. Science, including social science, values objectivity; decision-makers employ an independent source external to a programme (i.e. distant) to provide quantitative data, commonly assumed to be factual, logical and confirmatory. Qualitative data are conventionally deemed intuitive, biased, impressionistic and unreliable.

Patton argues that quantitative data are obtained via tools such as tests, questionnaires and numerical indicators, which he criticises as not free of bias. They merely mask or disguise it: “someone” has decided (i.e. subjectively) what to measure and how to measure it. Distance, he says, does not guarantee objectivity, but guarantees only distance. He quotes Scriven’s (1972a) questioning of the traditional narrow association of quantitative methods with objectivity. Scriven says that quantitative methods are no more synonymous with objectivity than qualitative methods are with subjectivity; he declares that qualitative methods are rigorous and valid, but that this depends on the quality of observations made by the evaluator/researcher. Nevertheless he retains a positive attitude to striving for the ideal of objectivity as a counter to bias.

Patton also quotes Lincoln and Guba’s (1982: no page reference) suggestion of replacing the term “objectivity” with an emphasis on *trustworthiness* and *authenticity*, through being balanced, fair and conscientious regarding multiplicities of perspective, interests and realities as observed in the work of investigative journalists. Theirs is not an absolute criterion of “objectivity”, but an emergent criterion of “fairness”, hopefully leading to an equitable decision. Like Patton (2002: 566-569) on researcher credibility, they stress the importance of interactions between subject and “reporter”, which determine the reporter’s perceptions, leading to a relative rather than an absolute criterion, and one measured by balance. A test of fairness is the length to which the reporter will go to test his/her own biases and rule them out. The issue then is not one of objectivity but about researcher credibility and

trustworthiness, about fairness and balance. In support of the use of qualitative research, Patton says

*“Qualitative methods are not weaker or softer than quantitative approaches, but **“different”** (Patton 2000:57, emphasis mine).*

“We no longer need to regard qualitative methods as provisional, because qualitative studies have already assembled a usable cumulative body of knowledge” (Patton 2000: 574, quoting Silverman 1997:1)

Patton also quotes Barone’s suggestion (2000: 169-170) that a new terminology is needed in place of rather outdated objective/subjective divides; he recommends using descriptive methodological language setting out the writer’s own inquiry processes/procedures. This more reflexive tactic may persuade the reader by intellectual and methodological rigour of the meaningfulness, value and utility of the result—paying special attention to the use of particular terms in specific contexts.

In the light of these arguments, I would argue that, while complete objectivity is a chimera, it is nevertheless important for me to provide reasons why my thesis is meaningful, valuable and useful: to set out how I acted to test my own biases, to ensure that my accounts are credible, trustworthy, fair and balanced. There are three main methods I employed to reduce the effects of bias.

Firstly, I attempted to place my material in the widest possible context of other people’s writings about health services in Pakistan, about the roles and limitations of NGOs in health care, and on health care for refugees. By accessing material on health care for Pakistani people compiled by planners, researchers and legislators, both external and indigenous to Pakistan, and reviewing different kinds of factual data, I would have to question my own understanding. I expected these writings to be more comprehensive, more detached and less locally focussed than my data. This would help me to be more even-handed in the study.

Secondly, I drew on my own earlier experiences of changing roles within UK statutory and voluntary organisations (as noted above) as well as with respect to FPHC. I have learnt how to change my orientation to previous work patterns and to colleagues in my professional career, and I carried these skills into the research setting. My first fieldwork visit in March 2001 was some three years after I had completed my Development Adviser task in 1998: this helped me to achieve some detachment from FPHC. In my first meeting with FPHC staff the day after I arrived in Pakistan, I emphasised my change of role and relationship. They responded to my third “change of hat” by invoking the External Evaluations of 1998 and 2000. These had criticised the NGO’s lack of research involvement:

staff saw my proposed activity as some mitigation of this. The Director of FPHC said that “research is a kind of evaluation: you (MMP) have to be neutral”. They hoped to learn something from this latest evaluative perception. I believe that this made them willing to allow me to see aspects of the organisation that they might have hidden from other researchers, so that my predilection to see the organisation in a positive light was more likely to be tested.

Thirdly, I did my best throughout the data collection to guard against acquiring only ‘positive’ data. With FPHC staff of all grades, as well as with service-users, I continually stressed my desire to hear ‘what you really think’. Pathan conventions of hospitality were likely to elicit responses aimed at telling the guest (as they perceived me) what they think she would like to hear. My interviewing technique was designed to explain my interest and counter this kind of restraint (see examples of interview schedules in annexes). My experience of these interviews varied: on one occasion I had to prod very hard before one group of male refugee patients would express opinions; on another occasion, a group of non-refugee women moved rapidly from criticism of FPHC into ventilating complaints about unsatisfactory living conditions in their village.

The debate on bias and the stance of the evaluator/researcher has been going on for many years, and seems unlikely to reach a conclusion that satisfies all critics. The above paragraphs comprise my rationale for approaching the research task in the way that I did. Another researcher might have chosen to address it differently—always with the possibility that they would not have had the strengths provided by my deep understanding of the history of FPHC from my own involvement over many years, mentioned below, as well as not having the limitations that such a commitment also provided. As an interviewer I posed no threat¹, though I have not hesitated to give due weight to critical views by including them in the thesis. There may, of course, have been other sources of bias of which I was unaware; but it would be a counsel of perfection not to carry out research unless we could be sure that was not so.

In any case, total objectivity is not achievable: but Scriven (quoted above) supports striving for the ideal as a counter to bias. Regarding those who have chosen to work in the field of development research, and the attempt to attain what is still generally referred to as objectivity, Crewe and Harrison put it neatly as follows:

“We recognise that a detached high ground is not tenable—we are part of development (being employed by development agencies)” (Introduction: 1998)

¹ But see below and chapter 5 for two exceptions to this.

Choosing a method—quantitative or qualitative?

One approach to the case study might have been to concentrate on quantitative data—assuming its availability—because measuring impact on people's health is relevant in the case of any agency claiming to provide health care. But this would be mechanistic and reductionist, and would not address "*process*", one of my key aims. My interest was essentially in the organisation's development, not in evaluation of clinical programmes. This is not to deny that there is scope for a quantitative study, either comprehensive or specific; nor is it to reject the illustrative use of some quantitative data in this study.

Qualitative data is appropriate to a case study. It is helpful in understanding the complexities of people's thoughts, opinions and feelings on sensitive issues, likely to be found in the complicated situation of Afghans who have been refugees in Pakistan for many years, large numbers having been born in the camps. Qualitative interviewing allows adaptability and flexibility when the interest is in uncovering a multi-layered account of what has been going on, when many people with different experiences, perceptions and responsibilities have been involved over a long period. Health care being a service provided for people by people, I needed to talk with patients as well as with employees and managers of various grades in the different services.

Semi-structured interviewing with a broad but controlled agenda enables collection of qualitative data and is more likely to release unexpected and potentially richer material than a structured questionnaire. It enables follow-up in later interviews of emergent themes, perhaps with people identified only in the course of the research (for example, the route by which PHC entered Pakistan, the roles of individual staff, sources of theoretical knowledge displayed by some individuals, and their motivation). A list of individual and group interviewees is included in the annexes.

Choosing a broadly qualitative method also suited my experience of semi-structured interviewing accumulated in several Scottish agencies. It also enabled use of the large amount of qualitative information on the NGO itself, gathered empirically at first hand over the years 1991-1998. Research required me to assess this from a more objective stance as a source of academic material. From having used this in earlier roles, for example to make a case to obtain funding from a donor, I needed to be more aware of contemporaneous agencies, of what might be missing from FPHC's activities, and of perceptions of FPHC by as many external individuals and agencies as possible.

Years of study

It is difficult to draw a distinct line between preparation and actual research, since the qualitative researcher begins analysing as soon as data collection begins; data-collection is a continuous process of refining, directing and further refining.

Years 1 and 2 1999-2001

were preparative in terms of reinforcing change of role and extending knowledge, via post-graduate classes in data collection, development research, and international health. I paid a short visit to Vienna to obtain basic historical information from people involved in starting the NGO. I submitted a formal research proposal in August 2000, but JSP's sudden illness in September caused a planned fieldwork visit to be postponed until spring 2001. Intensive reading on refugees, development, and research methods identified Primary Health Care (PHC) and its underlying principles as promoted by the 1978 Declaration of Alma Ata as an emerging theme influencing the research design.

Year 3 2001-2002

The second planned fieldwork visit had to be cancelled at short notice following the events of 11th September 2001 in New York. The safety of people from "the West" was a serious concern following the political and military repercussions of 9/11 for Pakistan. It was doubtful if a fieldwork trip would ever again be possible. A totally unexpected chance to interview Dr. Zamani, the original Medical Co-ordinator of the health project, meant a flying visit of 36 hours to The Hague in December 2001. Eventually the Pakistan trip did take place, in April-May 2002, but it had to be cut short, as explained below.

Years 2002-2004

The priority was to transcribe and analyse interview data. It was unlikely that time would allow me to become adequately skilled in electronic methods (e.g. NUDIST), so I used a method I had previously employed. I cut up transcribed material, reassembled it and entered it on cards under categorised headings. These corresponded not only to the research questions, but also related to themes emerging from interviews, e.g. how agencies involved communities in health care, whether they co-operated with other organisations, how far they understood the concept of PHC, how PHC had found its way into Pakistan, to what extent target populations used services, whether agencies made any special arrangements for disadvantaged patients, or were there gender differences in attitudes to family planning.

Drafting of thesis chapters began, and I interviewed several British nationals whose work experience in Pakistan as consultants and managers of NGOs had brought them into contact with the health project. This was in order to confirm data already gathered e.g. on external

perceptions of the NGO, and reasons for introducing Community Health Worker (CHW) training to Pakistan.

Research design: basis and plan

Mason's work (1996: 9-34) on qualitative researching helped to focus my ideas for a research design, forming a basis for some work described above. She suggests queries (some reflexive) as tools for facilitating thinking:

- What is the nature of the phenomena or social realities which I wish to investigate?
- What might represent knowledge or evidence of the social reality which I wish to investigate?
- What topic or substantive area is the research concerned with?
- What is the intellectual puzzle? What do I wish to explain? What are my research questions?
- What is the purpose of my research? what am I doing it for?

Addressing these queries helped to derive and refine objectives within the overall aim of the case study, all set out in Chapter 1. The first objective is broadly **historical**, namely to trace the evolution of the NGO itself and its changing relationships. Another is to **contextualise** the NGO against the background of locally available health care and the prevailing culture in refugee-affected areas of NWFP, and to consider **Primary Health Care and three underlying principles**. A related context is that of NGOs, particularly **health-oriented NGOs** and their effectiveness as providers. Whether this NGO has achieved its stated goal requires some examination of its **impact** on target populations. The purpose of the study was to draw some **conclusions** from the research and to **identify lessons learned**, as stated in chapter 1. I end the case study by raising some further questions.

To link the objectives with a feasible research plan, I devised five research questions emerging from Mason's "tools". I constructed five charts based on Mason's suggested model (1996: pp 22-23). These tabulate the why, who, and where of relevant data, and practicalities and ethical considerations of obtaining it. The questions are included in the five-page annex (one chart to each question) setting out the Research Design in detail.

Five research questions:

1. *Which specific aspects of primary health care (PHC) were adopted at different stages by UNHCR in Pakistan and FPHC, according to the definition of PHC as described in WHO's eight listed components in the Declaration of Alma Ata of 1978?*
2. *How far over time did each organisation implement the "Three Pillars" of primary health care (participation, inter-sectoral collaboration, equity)?*
3. *What alternatives (i.e. sources of health care) existed for refugees and for local non-refugee people? (This is not a true research question, but the work required that I inform myself about the local health care context).*
4. *What impact has each organisation (i.e. UNHCR and FPHC and GOP) had on the health of communities?*
5. *What factors have influenced changes in FPHC's practices and remit over the period 1980-2000?*

Notes on the research design

Time boundaries

Although in 2004 the NGO FPHC is still operational, I decided to limit the case study to a finite period of 20 years, 1980-2000. This should be long enough—on the analogy of human growth—for research to identify factors in the apparent maturation and survival of an organisation working with a largely settled population of rural poor people. This restricted period can be conveniently subdivided into five-year phases, to allow some summarising:

1. 1980-1984
2. 1985-1989
3. 1990-1994
4. 1995-2000

The phases impose a shape on what might be a rather tedious year-by-year catalogue, and also help to reveal trends in FPHC's growth.

Data selection: quantitative

Although I chose a qualitative method, assessing impact required some quantitative data. There is potentially a very large amount of routine statistics over the 20 years 1980-2000 relating to basic health and health care services for the two population groups, refugees and non-refugees, in NWFP. Such data should illustrate services claimed to be provided by each of the three agencies (UNHCR, GOP and the NGO), by citing, for example, incidence of various diseases, rates of utilisation, demographic information, or contraceptive prevalence

rates. Such data would enable some comparison between the services in terms of their impact on health.

I expected these kinds of data to be available from UNHCR sources, since UNHCR has oversight of health care for Afghan refugees in Pakistan, via Annual Reports, interviews with senior UNHCR staff, and evaluations if any. I expected to obtain similar information from NWFP Government sources, and I expected to fill in lacunae concerning FPHC itself. I could have looked for data referring to a broad range of activities including

Outpatient attendances (adults, children)	Family planning
Incidence/prevalence of infectious diseases e.g. measles, TB	
School health	Endemic diseases e.g. malaria
Lab/pharmacy provision	Diarrhoeal diseases
Physiotherapy	Maternal and child health
Health education	Nutrition information
Dental care	Nursing assistance
Water and sanitation	

Because of this huge and diverse field, I decided to restrict my search to Maternal and Child Health, including Family Planning, on the grounds that such data apply to a substantial proportion (roughly 75%) of the population of the refugees in camps, and also to the non-refugee population in local villages. Reasons for this limitation and its disadvantages are explained in more detail in Chapter 9 on "Impact on health". Although the decision apparently ignores men, it allows a fairly broad view of health and health care activities; many agencies (e.g. UNICEF) see Mother and Child Health (including Family Planning) as the core of PHC. Restricting quantitative data to one category, although a large one, helped to focus some questions in interviews with groups of registered patients.

Sources of data, qualitative and quantitative

In my possession in 1999 were copies of

- most but not all Annual Reports of the Austrian Relief Committee (ARC) from 1980 until 1993, and of its health project from 1990 until 1994
- all Annual Reports of FPHC from 1995 until 1999 (later also 2000, 2001, 2002, 2003)
- all formal documents and correspondence concerning setting up FPHC in 1995
- three official External Evaluations of FPHC: 1993/4, 1998 and 2000
- my personal journal (1991- 2002)

Annual Reports of any organisation are prone to distortion or bias, being written for external readers—maybe potential donors—and are therefore inclined to present a positive and optimistic picture while playing down negatives. They may be sketchy, skeletal and/or irregularly published because writers lack appropriate skills. The earlier ARC/PHC Annual Reports are quite full, always include a statement of audited accounts and incorporate several "mini-evaluations" of the NGO by visiting expatriate consultants, mostly Austrian. These make suggestions for improvements, based on detailed recorded critical observations of practice. The Annual Reports 1991-1996 were substantially the work of MMP and JSP in our roles as Administrator and Medical Adviser, and subsequently as Development Advisers. Incorporated quantitative data was the work of indigenous staff. As experienced professionals in our respective fields we tried to be as factual as possible, and to draw attention to risks and problems confronting the NGO as well as presenting the positives.

The three External Evaluations (1994 commissioned by the Austrian Chancellery, 1998 by FPHC itself and 2000 by CIDA (Canadian International Development Agency) were carried out by experienced and professionally qualified evaluators, and accepted as valid by these three agencies, which took them into account when making decisions regarding the NGO. References are included in appropriate chapters.

In-country agencies

listed in the research design charts, initially identified as further sources of data both quantitative and qualitative, based on their relationships with the NGO, include: UNHCR; the Commissionerate for Afghan Refugees and its Project Director (Health); Health Department of the Government of NWFP; ACBAR (Agency Co-ordinating Body for Afghan Refugees); and three donor agencies—CIDA, TAF (The Asia Foundation) and TVO (Trust for Voluntary Organisations).

Fieldwork

in UK and Europe

Interviews and visits to centres in UK and Europe some also including literature searches took place in Vienna, Oxford, London, The Hague and Geneva. JSP acted as amanuensis in Vienna; I took notes on all the others. The total number of interviews in UK and Europe was 15 (3 group, 12 individual).

in Pakistan

I conducted individual and group interviews at

- Head Office and Health Centres of FPHC (Mardan Town and Administrative Districts of Mardan, Swabi and Charsadda) in NWFP
- BHUs of the NWF Provincial Government's service for local non-refugee people, also in Mardan, Swabi and Charsadda Districts
- One BHU of the Refugee Health Programme in NWFP (Kohat District)

All visits to BHUs/Health Centres included group interviews with staff and patients. I tape-recorded most interviews during the first fieldwork visit. Some I did not, for reasons given below, but I always took written notes whether I used the tape-recorder or not—quite feasible when using an interpreter.

In Pakistan the total number of interviews was 45:

individual interviews	8 in 2001, 9 in 2002
formal group interviews	20 in 2001, 8 in 2002.

The 28 group interviews included a total of 141 people (average group membership was 5, range 2-12)

In addition I had many informal conversations and discussions, mostly with members of staff of the NGO FPHC, recorded in writing during or as soon as possible afterwards.

Practicalities of fieldwork

Advantages

Familiarity with country, local area, climate, health risks, culture, and limitations placed on women² meant that I had to spend minimum time on acclimatisation either physical or social. Established relationships with staff of FPHC and of some other organisations facilitated some fresh contacts with other individuals and agencies. As an older woman with in-country

² Local dress, the *shalwar-kameez* consisting of baggy trousers with loose over-shirt plus light scarf or *dupatta* is virtually compulsory for foreign females.

work experience, I was accorded "honorary male" status, so that it was acceptable for me to talk to both men and women. A male researcher would not have been allowed access to women's groups, far less discuss the intimate subject of family planning with them. "Honorary male" status also meant that driving unaccompanied on short local trips or for longer distances with only a driver as escort was acceptable. As there were no hotels or guesthouses in Mardan, other than those provided by a few international projects for use by their own expatriate staff, FPHC provided accommodation in its staff house. While this closeness may have increased risk of bias in spite of my awareness of this, there was no realistic alternative. Staying in a hotel in Islamabad or even Peshawar would have greatly increased travelling time, quite apart from being more expensive—for me and for FPHC, which provided driver and transport as needed. Although FPHC assumed responsibility for my comfort and safety during fieldwork trips (as in earlier years), I did not experience any attempt by FPHC to direct or influence my plan of work, until the later weeks of the second fieldwork visit in 2002, when external political factors intervened, as described later in this chapter.

Specific disadvantages:

Self-imposed limitations

JSP's health meant that I could not be away from home for more than roughly six weeks on any single trip to Pakistan. Most interviews during the first fieldwork visit were with patients and staff at three of the six FPHC Health Centres, because I decided not to approach any Government staff until I had permission from the Health Minister, who was out of the country until near the end of my stay.

External constraints

The second fieldwork trip of September 2001 was intended to concentrate on services other than FPHC. After the sudden cancellation because of the post-9/11 situation in Pakistan, the question arose as to whether fieldwork for the research could be completed.³ The unexpected trip to The Hague appeared at the time a substitute for the Pakistan visit, but turned out to be a bonus.

Eventually I did fly to Pakistan on 7th April 2002, intending to stay until May 23rd. Security in the form of extra armed guards was much more obtrusive than on any previous visit to Pakistan, at public buildings (including several armed men at St. John's Cathedral in

³ British Airways ceased flights to Pakistan immediately after 9/11 and did not restart until early 2004. The VSO Office in Islamabad suspended its programme, maintaining only a token office presence until late in 2003, when some volunteers went back to Pakistan. In September 2004, the UK Foreign and Commonwealth Office continues to stress risks in visiting Pakistan.

Peshawar), at private houses and at FPHC itself. FPHC's responsibility for my personal safety went beyond the customary protective courtesy to a foreign female guest. During this visit, I was the only expatriate in Mardan, where before the post-9/11 emergency there had been around 20, working for various international aid projects. On local trips I was told to sit in the back of the car so as to be less visible, and staff discouraged visits to the bazaar. On two occasions, in addition to the usual in-house armed guard, the Director of FPHC patrolled the staff house throughout the night armed with a revolver, as a result getting no sleep. This was where he, his family and I were staying.

The bomb attack on May 8th 2002 on a group of French engineers in Karachi resulting in 14 fatalities provoked increased anxiety at FPHC. Karachi is hundreds of miles from Mardan Town, but staff were immediately concerned after this most serious of a number of bomb incidents throughout the country. The French engineers had agreed to come to Pakistan only if they were guaranteed maximum security, i.e. by Pakistan army guards. FPHC staff were anxious not only for my personal safety (as representing "the West") but for the NGO itself, its people and premises. In the immediate aftermath of 9/11, they had been sufficiently alarmed to remove equipment and important documents from the Mardan Office for safe keeping elsewhere. Some other western-connected NGOs had been attacked at that time—a fairly local newly built health facility (not FPHC's) funded by EU money was burnt down.

In these circumstances of intensified anxiety it would have been irresponsible to burden FPHC with my continued presence, so with some difficulty I got a flight and came home on May 11th.⁴ The schedule of visits and interviews was therefore truncated; I was also suffering from amoebic dysentery. By the date of departure I had interviewed all individuals and groups at GOP BHUs as planned, but I had achieved only one trip to a health facility of the Afghan Refugee Health Programme, instead of the three intended. Pursuing the Peshawar Office of the Programme has produced no response, nor could I contact the GOP Provincial Health Department to obtain quantitative data for NWFP. Another trip to Pakistan is not possible.

Other features affecting fieldwork

Obtaining and using interpreters

All senior staff in Government, NGOs (including FPHC) were fluent in English (as were all non-British nationals interviewed in Europe) and interpreters were not needed. The local language of refugees and non-refugees is Pushtu. Interpreters were essential for interviews

⁴ Later the same month several indigenous staff were killed during an attack on the Christian School at Murree in the Punjab. Thereafter the school was closed, the Church of Scotland withdrew all its missionaries from Pakistan and the British High Commission staff was reduced to a minimum.

with patients, male and female, refugees and non-refugees; they were also useful where junior staff were not completely fluent in English.

Using interpreters has two main disadvantages:

- interviews take longer because slower
- the several stages of communication put at risk the meaning both of questions and responses

In the interests of impartiality, FPHC senior staff had tried to find skilled local people (non-staff) for interviewing within FPHC, but without success. It was eventually agreed that two female FPHC staff (1 doctor, 1 LHV) both fluent in English would act. This proved helpful because both were familiar with health issues and were well known to patients, who communicated readily. They interpreted for all FPHC female patient groups, refugees and non-refugees. Communication was slow as expected, but in my opinion misunderstanding was not a problem. While using these women as interpreters might have led to bias because of possible patient reticence, in practice the doctor's fears that patients would not talk were unfounded—some female groups were very talkative and had to be shushed more than once—which admittedly may have led to omission of some of their observations, negative as well as positive.

The one external male interpreter secured towards the end of the first visit was a teacher, whose English turned out to be not very fluent, who did not always seem to understand the questions to be put, and who was prone to offer his own opinions rather than act as the channel for those of others. He interpreted on only two occasions, with groups of refugee and non-refugee male patients, a few of whom did have some English, which compensated to some extent.

I had hoped that the two FPHC female staff would again be available for my second trip in April/May 2002, but both were unwilling to work outside their own organisation. This accords with the persisting cultural restrictions on women's mobility and activities—though as "Doctor Sahib" it had been acceptable for the lady doctor to interpret for a group of male FPHC patients at the Health Centre where she was deputy Team Leader. For this fieldwork trip the male Administrator of FPHC acted as interpreter with staff and patient groups of GOP BHUs. He proved acceptable even to female patient groups, being known locally, and probably also because I was present throughout; this acceptance may have influenced GOP patients to stress their negative opinions of the GOP service.

Membership of groups interviewed

All individuals and all members of groups waived the offer of a consent form and agreed verbally to being interviewed (many were in any case illiterate). Staff at all agencies were agreeable to being interviewed in mixed groups i.e. male and female together. With patients, both refugees and non-refugees, the proprieties of segregation had to be observed, which in effect almost doubled the number of patient-group interviews.

I had intended to devise a method of random selection of participants based on family registration cards. Time did not allow for this, and in any case agencies other than FPHC do not use family cards. It was simply a matter of who turned up on the days I visited the health facilities. I interviewed staff groups first, and then asked them to arrange groups of 6-8 patients of varying ages from among those attending that day. I have no reason to suppose that any of these groups were manipulated beyond that proviso (with two exceptions, at the same BHU, noted below). One group of refugee women turned out to be three generations of the same family, and one non-refugee women's group was fairly fluid in that there were one or two late arrivals or early departures, probably out of curiosity—or in the latter case perhaps boredom. At one GOP health facility the local *khan* (landowner) happened to arrive and insisted on participating in the patient group interview. This did not appear to inhibit unduly the contributions from the other men, in spite of his rather dominating presence.

Recording interviews

Where possible, I tape-recorded, and most individuals and groups consented. But electricity is not dependable (or universally available), and sometimes generators create more problems than they are worth. It was safest to take notes on all occasions. One group of refugee women, having agreed to tape-recording, concluded the interview by asking me not to tell their men-folk that they had been recorded. This appears analogous to the cultural prohibition on taking photographs of women. Another refugee women's group was agreeable to tape-recording, but deferred to one of their number who objected. I routinely said that I did not want to know people's names, and no individual or group objected to my writing notes. I wrote up all interviews as soon as possible, an aid to identifying themes and information to be checked against later interviews. One senior employee of a donor organisation asked not to be taped, saying he did not like these machines, but he did not object to my taking notes.

Co-operation and non-co-operation

At FPHC, I experienced full co-operation from staff at all levels, though sometimes their commitments meant that I could not have a driver or interpreter at a time I would have

preferred. Patients male or female, refugees or non-refugees, participated readily in interviews, though occasionally, as noted above, were shy about tape-recording. Neither patients nor staff at any of the six FPHC Health Centres knew when (or even if) I would visit. In fact I visited three.

Provincial Government's Health Service: Official permission at the most senior level was important, especially during the second fieldwork trip when security had become so intense. When she returned from her overseas trip, the Provincial Health Minister willingly agreed to be interviewed (15.03.01), and arranged a formal letter of introduction to facilitate co-operation at middle and field levels. Her successor, also a woman, provided a similar letter to cover my second fieldwork visit⁵. I was free to drop in on any GOP BHUs without any advance warning. District Health Officers in Swabi and Charsadda, and the Depute DHO in Mardan District, all mobile members of staff, made themselves available by appointment.

Afghan Refugee Health Programme: in 2001, Deputy Project Director (Health)–DPDH–who had been ten years in post, co-operated generously by supplying a great deal of background information at a long interview 21.03.01⁶. His senior, the Project Director Health (PDH) was in an "Acting" capacity and new to the job. The Programme Officer (Health) of UNHCR in Islamabad was similarly helpful, in spite of being overloaded with work, following staff cuts and a recent influx of "drought" refugees from Afghanistan, accommodated in two very large re-opened camps, Shamsatoo and Jallolai.

The following year I obtained verbal permission for research from the new PDH himself. I was required to specify which BHUs I wanted to visit and on which days, and I was expected to use driver and transport provided. I was unable to visit the first of these BHUs on the agreed day, because I became ill. A drop-in visit (using FPHC transport) on another day was clearly resented by the Medical Officer (although I had already met him) partly at least because the Director of FPHC accompanied me as interpreter. Although I did conduct three group interviews at this BHU, the MO controlled these by selecting staff (not the full complement) and patient participants, and remaining present throughout the male patient group interview.

A Peshawar-based lady doctor with senior responsibility for primary health care in the Refugee Health Programme failed to keep an appointment. This was an attempt at avoidance, as became evident at the eventual reluctant interview. Both she and PDH said they were new in post and could not provide past records of the Refugee Health Programme. Attempts to

⁵ This lady was not available for interview, being pre-occupied with a recent incident when her brother had been kidnapped.

⁶ Later the same year he died very suddenly, aged 35.

pursue this via PDH's secretary have been unsuccessful. It is difficult to know how far my unannounced visit to the Refugee Programme BHU has been a factor in this lack of response.

Donor contacts were almost all co-operative, with one exception. The Peshawar representative of the donor NGO Trust for Voluntary Organisations (TVO) was over an hour late for an appointment; several different excuses proffered by a member of his staff and later by himself indicated that this also was an example of avoidance. I had however interviewed a senior member of TVO staff in Islamabad.

Conclusions

The methods chosen to implement the research design, apart from data already in hand, depended largely on co-operation by a number of people. Those people and agencies based in the UK and in Europe readily shared their recollections as well as providing additional documentation or suggesting other contacts. An approach (during a holiday) to UNHCR in Geneva in search of health statistics was initially unproductive: I was several times referred back to Pakistan which had already yielded nothing. I arranged a second personal visit to Geneva; with help from UNHCR Archives and Library staff this produced some information on refugee statistics, but it uncovered no quantitative health data.

In Pakistan, individuals, groups and organisations were on the whole responsive. All levels of the Provincial Government's Health Department co-operated fully. The defensiveness evident on informal visits to two GOP BHUs in the 1990s was not displayed this time round: there was a general frankness and willingness, even eagerness, to share problems and frustrations. Representatives of donor organisations responded promptly to requests for interviews and spoke readily, apart from the one exception mentioned above.

There can be no more powerful example of research plans being overtaken by events than 9/11 and its consequences, which still reverberate in Pakistan in 2004. Data collection was thus even more limited than anticipated. FPHC was entirely helpful and supportive of the research, and it was imperative that I reciprocated by not increasing their anxiety and prejudicing their security by staying on.

It was disappointing that later visits planned to BHUs of the Afghan Refugee Health Programme had to be cancelled because of my premature departure from Pakistan. What was surprising was the reluctance (or inability) of two senior officials of the Programme to provide statistical health information or any Annual Reports, apart from one document based

on the Health Information Systems Report for year 2001, very recently devised by the Control of Diseases Center (CDC Atlanta). Also surprising was the apparent lack of refugee health data at either UNHCR or WHO in Geneva. The attempts to control proposed visits to Refugee Programme BHUs (and the one actual visit) were in marked contrast to almost all my other fieldwork experiences, and beyond providing some contextual allusions, effectively reduced the possibility of meaningful comparison of the Afghan Refugee Health Programme with either FPHC's service or that of the Provincial Health Department.

Whether or not comparison is relevant or possible, an appreciation of the history of the NGO FPHC is necessary for understanding why it was created and the reasons for its later direction. The next chapter will relate that history throughout the twenty years selected as the time-scale for the study.

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CHAPTER 3

A HISTORY OF FPHC (FRONTIER PRIMARY HEALTH CARE)

The organisation now known as Frontier Primary Health Care (FPHC) began its activities in 1980. It is still fully operational in 2004, but as explained in Chapter 2, the case study is limited to the first twenty years, divided into four 5-year phases. In this chapter I recount the organisation's history during that time, first as the Austrian Relief Committee for Afghans (ARC), later as the primary health care project of ARC (ARC/PHC), and finally as FPHC.

This historical account derives partly from available Reports¹ and documents, including my personal notes and journal written during my own (MMP) and my husband's (JSP) association with the NGO from 1991-2002. The chapter also uses material from interviews with people involved at various times in different capacities, either as committee members or staff of the organisation, as professionals from other agencies with related responsibilities, or as registered patients of FPHC, whether Afghan refugees or local Pakistani people.

This chapter also provides some contextual information about the Afghan refugees in Pakistan and the arrangements for their health care by the Government of Pakistan (GOP) in partnership with the United Nations High Commission for Refugees (UNHCR).

The first phase 1980-1984: beginnings and background

Professor Christian Reder and Mag. Wolf Zacherl are two people associated with the organisation since 1980, whom I interviewed in Vienna in March 2000. They credited Dr. Alfred Janata as its founder and continuing source of inspiration until his sudden death in 1993. Following the Soviet invasion of Afghanistan in December 1979, Dr. Janata, an Austrian anthropologist with long-standing interest and practical experience in Afghanistan, made a radio appeal on behalf of the many refugees fleeing from their homeland. Some went into Iran, but most, especially those from Afghanistan's eastern provinces, made their way into Pakistan, mostly into NWFP, some also going to the province of Baluchistan. Both of these provinces border with Afghanistan (see Figure 3.1 for map). The Austrian public responded generously to the appeal with financial donations: according to ARC's 1981

¹ In 2001, Annual Reports of the original organisation for the years 1980, 1981, 1982, 1983, 1986 and 1987 were found to have been destroyed by insects. During a visit to Pakistan in 1997, in anticipation of future work, I had taken notes on these Reports when they were still extant, but I did not record page numbers. Exact references from these are therefore not possible.

Figure 3.1



Source: Godfrey (1993: 293)

Annual Report there were 8000 donors, who donated a total of 3.3 million Austrian schillings (AS)—the budget for that year was AS 428,000. Some individuals, including Prof. Reder, showed a practical interest, as did a number of organisations. This culminated in the formal registration in Austria of the Austrian Relief Committee for Afghans (ARC) in March 1980. Membership of ARC included some individuals and also representatives from organisations such as Amnesty International, Caritas and Oxfam. Dr. Janata became Chairman of ARC and Wolf Zacherl joined ARC later in the year. As an accountant, his expertise was in financial management; he had connections with an Austrian NGO, Volkshilfe, which engaged in disaster relief and humanitarian work, with some developmental components.

In the first months of 1980 the Vienna Board (the newly constituted governing body of ARC) sent a small party to NWFP to assess the situation and make plans. ARC was thus one of the earliest international NGOs active in the emergency in Pakistan (Godfrey 1993: 310). The deputation was led by Prof. Reder, who had in the 1970s acted as a management and health system consultant to the Austrian government and had been involved in foreign projects including in Nicaragua. Other members of the party were an Austrian woman doctor, and Nassim Jawad, one of the 20 or so Afghan students then living in Vienna, considered by Prof. Reder to be the most able of them. On this visit, according to Prof. Reder, during a tour of the camps, the Austrian deputation was told in discussions with camp elders (the traditional spokesmen) that a proper medical service was what they (the elders) wanted.

Prof. Reder explained that the basic structure of the new NGO was the joint work of himself and Nassim Jawad. ARC set up two offices, one in Vienna concerned with publicity, fund-raising, general and financial management, and sending supplies, the other in Peshawar, capital of NWFP, with Nassim Jawad as Director. Staff in the Peshawar Office were salaried, but the Austrian members of the Vienna Board worked as volunteers, i.e. unpaid.

By the end of summer 1980, a fledgling medical programme had been devised and was in operation. The Peshawar Office was responsible for liaison with Vienna, with UN agencies, with the Austrian Embassy in Pakistan and with the Government of Pakistan (GOP), for keeping accounts, for hiring staff and for implementing on-the-ground policy. ARC's first Annual Report (1980) mentions that the Peshawar Office had also to deal with many individual personal problems of refugees presenting on its doorstep. Some of these received financial help (amounts not stated); but the account in this Report of the first year's activities shows that from the start the organisation's principal activity was in the field of medicine and health, although its Peshawar Director was not himself a health professional.

The refugees

Refugees from Afghanistan were not a new phenomenon in Pakistan. About 1500 entered in 1973 following the overthrow of King Zahir Shah, and over 100,000 in 1978 after further political disruption. A GOP pamphlet claims that these relatively small numbers had posed no special problem within Pakistan: Pakistan made them welcome, and coped with the situation on its own:

"Pakistan and its people have faced the situation with courage, compassion and humanitarianism, treating the Afghans both as brothers in faith and members of the international fraternity of human beings. They have offered them shelter, food and a respectable mode of living on a temporary basis, hoping that when conditions in Afghanistan return to normal they would go back to their homes with honour and dignity, the two dominant national traits of the Afghan people...For nearly two years—from April 1978 to January 1980—the Government and people of Pakistan bore the burden of refugee care practically single-handed." (GOP pamphlet 1984: 4,7,8).

The Soviet invasion of Afghanistan in December 1979 sparked off much greater waves of refugees—over 400,000 by the end of January 1980, continuing until there were over three million in 1984. The massive influx of 1979/80 alerted GOP to the need for more pro-active intervention by itself and for help from international agencies, including UNHCR.

At first the Afghans squatted anywhere—by roadsides, on open land—until GOP ordered them into "tented villages"—camps—on designated sites: the 1980 ARC Annual Report says there were 102 by the end of that year. More were created until there were eventually over three hundred (350 according to the 1984 pamphlet cited above). Three veteran staff members of what is now FPHC, themselves refugees, interviewed in March 2001, remembered these early days vividly, having been among the first arrivals in 1980; two of these three men were still living in the camps when I interviewed them. The 1984 pamphlet states that GOP provided tents and a small per capita grant from its own resources. Unlike refugee provision in some other countries, e.g. Hong Kong in the 1980s and 1990s (UNHCR 2000: 109), no restriction was imposed on movement in and out of the camps, so that the Afghans were free to look for work or engage in commerce. At the end of 1980, according to the ARC Annual Report, the estimated number of refugees in Pakistan was probably about one million, but inaccuracy is an acknowledged and persistent characteristic of refugee figures, because of the conditions prevailing at times of disruption. The 1980 ARC Annual Report surmises that the influx was at the rate of about 80,000 per month, and while double counting was likely, the numbers of refugees who did not go into camps but found ways to merge with the general population probably compensated for it, according to the Report. See Figure 3.2 for map of distribution of the camps at March 2001, much as they were since the early years.

Coping with the refugee influx of 1979/80 onwards—the general perspective, including health

Colonel Altaf-ur-Rahman Khan, a senior army medical practitioner concerned with refugee health since 1980, and at time of interview with the title of Medical Co-ordinator, provided a personal account in an interview in April 2002 of the Pakistan Government's strategic response to the large-scale refugee influx of 1979-80. Within the GOP structure a Disaster Relief Cell already existed (i.e. in 1980), to cope with "normal" emergencies such as floods and earthquakes. When General Zia-ul-Haq, the then President of Pakistan and his advisers realised that the escalating refugee situation was beyond the capacity of the Cell, a Presidential Directive determined that SAFRON would be the responsible Ministry. Its full title, dating from colonial times, is States (i.e. the former Princely States) and Frontier Region Ministry of Kashmir and Northern Areas. A Chief Commissioner for Afghan Refugees was appointed, and by the end of 1980 a Director of Medical Services.

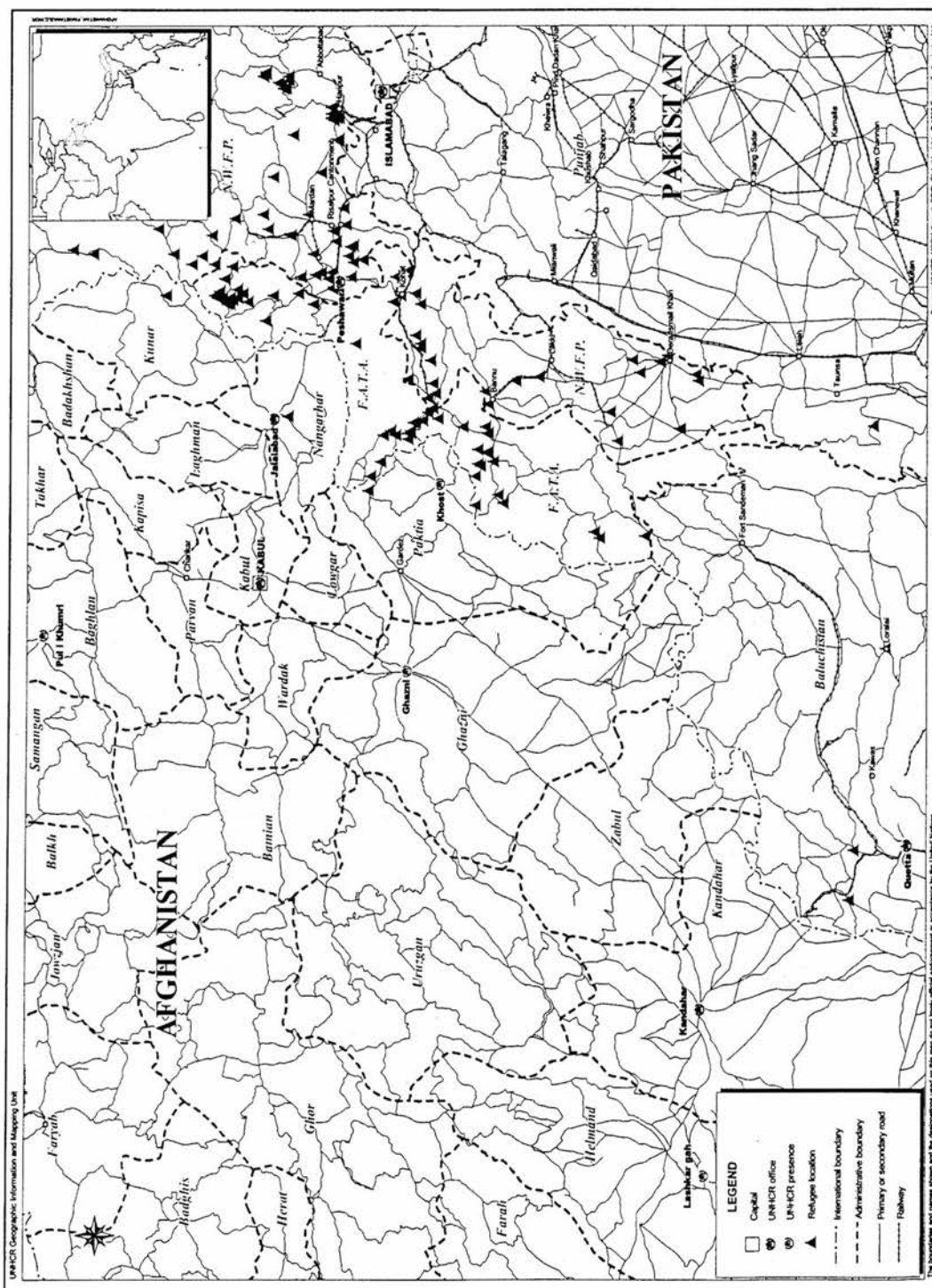
In making this latter appointment, according to Col. Altaf, GOP recognised that refugee health was a major issue, having taken into account a survey carried out in early 1980 by Médecins sans Frontières (MSF). A brief description of this survey appears in the 1985 Report of the Afghan Refugee Health Programme, the first one to be printed, and now rarely obtainable; it also includes a short account of the origins and history of the Programme to that date.² According to this Report (GOP 1985: 4-9) MSF advised that there were wide variations in the health status of the refugees, but while services and supplies were at that time only partially organised, it found no evidence of large-scale malnutrition and epidemics of measles only; that is to say, the refugees' health status was comparable to that of their country of origin. This Report also states that initially GOP had provided some medical care for refugees via its own existing local health facilities, supplemented by setting up dispensaries in some of the tented villages, many of these being located far distant from any medical agency. UNHCR, in its customary partnership role with governments of host countries, combined with WHO, UNICEF and the Provincial Government of NWFP to draw up plans for an Afghan Refugee Health Programme in anticipation of the numbers of people in need becoming too great a burden on Pakistan's own medical services. Col. Altaf commented that a fear of waste and corruption influenced the decision to make special arrangements for the refugees.

² Col. Altaf in providing a copy of this Report cautioned that it might not be entirely accurate: but the difficulty of obtaining any documentation about the early years of the Refugee Health Programme affords it some status.

Figure 3.2 Refugee Camp Locations

Pakistan - Afghanistan, refugee locations

As of March 2001



Source: UNHCR NCGIA through GRID, Global Insight (copyright Europa Technologies Ltd.)

This 1985 Refugee Health Programme Report provided by Col. Altaf outlines the organisation of the new official UNHCR/Refugee Health Programme field medical services. These were based on mobile medical teams, providing curative care only, but the Report acknowledges that they were not the only source of medical aid. The international response to the refugee emergency stimulated prompt NGO interest so that even in 1980, ten health-oriented NGOs were active in the field as well as the UNHCR units. As noted in the ARC 1980 Annual Report, a few were Pakistani in-country NGOs, one was Saudi Arabian and the others, including ARC, had bases in western European countries or USA, e.g. Save the Children, Union Aid, International Rescue Committee, International Committee of the Red Cross. Each individual NGO, as an autonomous body, had the status of partnership with UNHCR, just as GOP had, and was free to operate independently and devise its own priorities and policies. In practice all health-oriented NGOs, including ARC, adopted the mobile team model offering curative care, but a few did set up fixed dispensaries or clinics, also curative-oriented. For example, Save the Children (SCF) UK ran a fixed clinic in Badaber refugee camp in NWFP, staffed by a doctor and two nurses (interview with Dr. John Seaman, a senior member of SCF staff, London, July 2001; also Godfrey 1993: 310—see Table 3.1).

All mobile teams, whether under the auspices of UNHCR or of an NGO were quite small, and typically consisted of doctor, lady health visitor (LHV) or nurse, possibly one or two paramedicals, perhaps a pharmacist. The Provincial Government of NWFP provided some support to the Refugee Health Programme. For example, Health Department mobile teams implemented the Expanded Programme for Immunisation (EPI) and insecticide spraying against malaria, but the service in these early days had been poorly co-ordinated. These preventive programmes were limited, and mobile sanitation teams staffed by GOP personnel, though planned, were never established. The Refugee Health Programme was more effectively implemented in NWFP where 23 NGOs were active, compared to 7 in Baluchistan. (GOP 1985: 57-70).

Table 3.1 Charitable agencies providing basic health services for Afghan refugees in 1980

AGENCY	COUNTRY OF LEGAL REGISTRATION	SERVICES PROVIDED
<u>North West Frontier</u>		
International Committee of the Red Cross (ICRC)	Switzerland	4 mobile teams
Inter-Aid Committee	Pakistan/United States of America	2 mobile teams
CARE-Pakistan	Pakistan/United States of America	Potable water supply
International Rescue Committee	United States of America	4 mobile teams; 20 dispensaries
Save the Children Fund	United Kingdom	1 mobile team; 3 dispensaries
Union Aid for Afghan Refugees	West Germany	2 mobile teams
Pakistan Medico International	Pakistan	2 mobile teams
Austrian Relief Committee for Afghan Refugees	Austria	2 mobile teams; 1 health clinic
Edara Ahya-ul-Uloom	Pakistan	1 mobile team
Saudi Arabian Red Crescent Society	Saudi Arabia	2 mobile teams
<u>Baluchistan</u>		
Pakistan Medico International	Pakistan	1 mobile team
10 Agencies	7 Countries	21 mobile teams; 24 dispensaries or clinics; one water supply project

Source: Godfrey (1993: 310)

A new perspective on Refugee Health Care

In 1982, this 1985 Report explains, a conscious attempt was made to change gear, following the arrival of a WHO/UNHCR consultant to the Refugee Health Programme—the "Senior Health Co-ordinator". Godfrey (1993: 343) outlines his suggested strategies for development of the Programme, including:

- providing a full range of basic health services, preventive, promotive and curative
- integrating all vertical projects within the refugee health service structure, including malaria control and immunisations
- improving co-ordination of the various organisations involved in the Refugee Health Programme
- preparing and introducing adequate community involvement...training different categories of health workers
- standardising as far as possible the service structure, staff, salaries, supplies and equipment in the health units

Broadly, these strategies, which Godfrey explains were based both on earlier evaluations and on the Co-ordinator's own observations, point in the direction of primary health care—"PHC", as recommended at the Alma Ata Conference of 1978.

Provincial Medical Advisers already in post in Pakistan had suggested such a move, so that a climate existed for improved integration of health work, re-orientation of health staff, and training Community Health Workers. 1982-84 saw the following changes in the Refugee Health Programme, set out in the 1985 Report quoted above:

- re-orientation courses introduced for doctors and LHVs (open to NGO personnel as well)
- middle-grade Field Service Medical Officers appointed, to strengthen practice supervision, each responsible for a specific geographical area
- regular co-ordination meetings started
- mobile service discontinued in favour of fixed Basic Health Units (BHUs) to serve the camps, each BHU to cover about 10,000 people. Some of these BHUs were in tents (GOP 1985: 5-8)

All health care at BHU level was free to the refugees. GOP made secondary level care available to all refugees at no cost, by referral on from BHUs to Government hospitals, an arrangement which has continued since then (confirmed in interviews with senior FPHC

staff April 2002). Some NGOs set up small specialist hospitals in Peshawar for refugees, for example in obstetrics and gynaecology, in eye conditions, and in treatment of war-wounded (personal observations/visits in 1991-2). Management of preventive activities in the camps such as immunisation and malaria control, previously the responsibility of the Provincial Health Department, was transferred to Project Director Health (PDH), a senior official accountable to the Provincial Commissioner for Afghan Refugees in NWFP. The Commissionerate handled all general administration concerning refugees and camps; a member of administrative staff from the Commissionerate was located in each camp, still reportedly the case in 1991.

The role of NGOs in refugee health care provision—and ARC's part

UNHCR recognised NGOs as useful partners in an increasingly difficult situation, particularly when they had access to finance and expertise which could supplement UNHCR/Refugee Health Programme resources. Some set up hospitals as mentioned above; others had expertise in specific diseases e.g. Italian Co-operation for Development (ICD) initiated a TB control programme implemented by working through the Refugee Health Programme and through NGO BHUs; Médecins du Monde teams undertook water and sanitation installations in camps, later handing over to DACAAR, a Danish relief organisation. Other NGOs, one being ARC, were allocated responsibility for general health care, but each of these NGOs was limited to one or two camps.

The two camps allocated to ARC as agent for the delivery of refugee health services were Gandaf and Baghicha camps in the Mardan and Swabi Districts of NWFP. They are situated along the same road, metalled for most of the way, roughly two and three hours' drive from the Peshawar Office. ARC started by operating a basic curative service from two mobile units, that is, it provided treatment to those refugees who sought it—and were able to attend. By the end of 1980 according to its Annual Report of that year ARC had set up a fixed clinic in the town of Mardan, the second largest town in NWFP (pop. 148,000). This was intended as a Mother and Child Health facility (MCH), the Vienna Board taking note of the needs of this vulnerable group. ARC's Annual Report of 1980 also records the setting up of a small laboratory with a technician.

ARC published Annual Reports from its inception. My notes on the 1981 Report record several points in addition to the historical details mentioned above, early insights which appear to have some bearing on the future development of the organisation :

- **self-help by the refugees to be encouraged** (this from the 1980 Report)
- **regular meetings for NGOs started by ARC**
- **cultural restrictions on the movement of women** noted (affecting female staff as well as female patients)
- **refugee situation recognised as not one of emergency relief but long-term**—a development aid project for an unlimited period.

Three other items first noted in the 1981 Annual Report affecting ARC's development:

1. Provision for children—social education, and more formally, for girls

Another small deputation from Austria having expressed concern about the refugee children, the Vienna Board undertook intensive publicity in Austria. In response to this appeal, St. Johann School in the Tyrol began to raise money through local "flea-market" type events to create a "kindergarten" for the children of one camp. This took the form of a play park adjacent to Gandaf camp, supervised by two *chowkidars* (janitors) and furnished with equipment such as swings, roundabouts and see-saws, all made by camp residents. The park was planted with trees and flowers. It also included a classroom where about 50 girls aged approximately 8-13 received instruction in craft work, health education and basic literacy from two female staff, who might or might not be qualified teachers, depending on availability. When they completed their course, the girls received a sewing machine, intended to help with augmenting the household income.

This case study will not examine the play park/classroom activity in detail; but its existence at this early date demonstrates that at ARC there was some understanding of the link between the sectors of education and health. It also addressed the gender question: the refugees' attitude to education, and especially that of girls, was traditionally not a positive one.

2. Staff turnover at ARC—and an exception

The 1981 Annual Report notes a tendency towards high staff turnover, but no actual figures for health care staff turnover are given until the 1986 Report. Educated (i.e. richer) Afghans moved on when they could, usually to Western countries. A total of 67 members of staff, 23 being doctors and 17 nurses or LHVs were lost to ARC during 1980-1986. The number of doctors (in addition to the one senior practitioner/manager) employed at any one time during these years would not have exceeded three or four, but the total number of doctors who left during that time was 23. Nurses or LHVs who were lost numbered 17. These were formally

qualified women, some Afghan, some Pakistani, and numbers employed at any one time in the early years would have been in single figures—four or five. The 1986 Report breakdown of losses is shown in Table 3.2 below in numbers and percentages:

Table 3.2 ARC health care staff turnover 1980-1986

Reasons for leaving	Numbers	Percentages
Going to western countries	20	31 %
Going to other organisations for higher salaries	7	11
On <i>jihad</i> (i.e. fighting in Afghanistan)	4	6
Marriage (this affected only female staff)	4	6
Other reasons or no notification	32	46
Total	67	100 %

An exception to the pattern of moving on, and crucial for the future of ARC's health activities, was one of the first doctors to join ARC. A young Afghan from a powerful *khan* (landowner) family, Dr. Abdul Rahman Zamani, who had qualified in Afghanistan and had just completed his house jobs, escaped from the political turmoil in Afghanistan in the late 1970s and arrived in NWFP (interview in The Hague, December 2001). He said that at first he found work locally, including a short period in the UNHCR/Refugee Health Programme, but disliking the bureaucracy, he joined ARC in 1980. The 1981 Annual Report records his committed work. His association with ARC lasted until he had to leave Pakistan in 1991. When he started work with ARC, he and another Afghan medical colleague (who *did* move on) ran ARC's two mobile clinics for refugees.³ In the evenings Dr. Zamani saw local Pakistani villagers near Gandaf camp who came seeking treatment, but it is not clear whether villagers paid for this service. During his visit to Pakistan in 1981 as Chairman of ARC, Dr. Janata remarked on the long hours worked by ARC staff, sometimes until after midnight, though the Report does not make it clear whether he was referring only to the mobile health teams or to all ARC staff.

3. External comments on ARC's health care in its first phase

An Austrian medical consultant, Dr. Gebhardt Breuss (who also made positive comments on Dr. Zamani's work) while being critical of over-reliance on "pill medicine" and over-use of injections by doctors and patients, saw little difference in 1981 (according to the Annual Report of that year) between ARC standards of health care practice and what he observed on

³ The Annual Report for 1980 records an average treatment period for patients of five minutes, with over 100 patients being seen per day.

a visit to a BHU run by the International Committee of the Red Cross (ICRC). He also observed that when no woman doctor was available, Mother and Child Care at ARC virtually ceased to function. He acknowledged that pressure on ARC's service made it difficult to implement suggestions for improvement in the health work, but he advised that most problems were not medical but strategic and organisational. He recommended a different approach, stressing prevention, health education, use of paramedical personnel and a standard drugs list.

Two years later, the 1983 ARC Annual Report records the comments of another Austrian medical adviser, Dr. Reinhard Dörflinger, a pioneer of social-oriented medical group services. Following his two-month visit May-July 1983, he compared the ARC health work favourably with what he observed on visits to ten other non-ARC camps. UNHCR/GOP Afghan Refugee Health Programme BHUs were staffed by non-Pushtu-speaking personnel who remained curative-oriented, and other NGO-run BHUs varied from chaotic to exemplary, in terms of organisation, cleanliness and co-operation with the refugees—in which latter category he placed ARC, in spite of it still operating from tents at the time. Dr. Dörflinger recommended concentration on improving quality of service rather than expansion, more stress on preventive work and exploration of methods of health education, more training and clearer job differentiation within teams, and continued use of external consultants.

The introduction of PHC for Refugees, and the role of Save the Children (UK)

The Afghan Refugee Health Programme sponsored by the UNHCR/GOP partnership began to change direction in 1982/3, as mentioned above, following the arrival of the Senior Health Co-ordinator. Under the auspices of the Programme, and in conjunction with UNICEF, Save the Children UK (SCF) set up a series of workshops in 1982-3. Godfrey (1993: 352) notes that a UNHCR/UNICEF seminar in 1981 had concluded that cultural restrictions on the movement of Afghan women and involvement in activities outside their own homes prevented implementing specific proposals to train any of them as basic health workers. However, SCF's involvement arose from its own dissatisfaction with the limitations of the curative clinic model which it was operating at Badaber refugee camp (Refugee Health Programme Annual Report 1985: 8). Dr. John Seaman at SCF in London July 2001 made the additional point that SCF's conclusion from its experience with the curative clinic model in African settings was that it put undue pressure on secondary provision. SCF chose to move towards a policy based on PHC, with the following goals:

- to reach more of the refugees
- to promote better understanding of health
- to help people to take more responsibility for their own health

SCF introduced this new policy in Badaber camp where it already had a presence. According to Margaret Usher, then Senior PHC Adviser to SCF (interviewed in Geneva September 2002) it attempted this in response to camp residents who wanted not only treatment, but to know how to stop child deaths and how to protect the health of their families, she said. SCF introduced its new policy only after conducting local research and assessment of what changes would be acceptable and were likely to be effective, given the local cultural norms. SCF therefore devised its own teaching materials. Gradually it was able to introduce training, in particular training of Community Health Workers (CHWs) who were to be volunteers from among the camp refugees themselves, proposed by the community. At first, these were men only, but the principle of community participation was established. By encouraging other NGOs to accept the idea of training CHWs in first aid, health education, hygiene and symptom recognition, SCF contributed to the swing towards PHC within the UNHCR/Refugee Health Programme, among NGOs and particularly at ARC. According to Margaret Usher, once male CHWs had become established, the camp residents themselves began to ask for women to be trained.

PHC is introduced at ARC

Within ARC, the shift towards PHC was managed by Dr. Zamani. At interview in The Hague, he identified several factors which influenced his professional orientation in his early years with ARC:

Firstly, when the transition was made from mobile to fixed units in Gandaf and Baghicha camps, he formed the opinion that continuing to treat symptoms was not tackling the underlying causes of ill-health.

Secondly, he was specifically interested in methods of improving general health; he felt he needed to search for another model.

Thirdly, he had started simple health education by explaining to small groups of waiting patients what could be done to prevent the condition affecting the individual patient he was examining (privacy as understood by people from "the West" is not a feature of this culture).

Fourthly, as the UNHCR-sponsored Refugee Health Programme began to re-orient itself towards PHC, it made practice workshops available to NGO staff.

Dr. Zamani admitted that being an Afghan himself helped in effecting change. He thought from his personal experience that change should be gradual, given the attitudes of the refugees who were mostly from poor and mountainous areas of Afghanistan. He recounted how, for instance, in rural communities where skilled obstetric help was not available, the people considered low birth-weights desirable, to enable an easier birth. They kept new-borns indoors for the first 40 days of life (a practice still observed in some remote areas of Pakistan, according to senior staff of FPHC in 2002). The three veteran FPHC staff interviewed in 2001 recalled how Dr. Zamani had worked very long hours, and how he had sent staff to help with the mud-plaster houses camp residents were building to replace the tents, sometimes helping with his own hands.

The 1982 Annual Report of ARC credits Dr. Zamani with innovations in practice such as medical examinations for school children, and also at a deeper level, in building trust with the population of the two camps to create pre-conditions for preventive measures. He began to train CHWs himself, and also Traditional Birth Attendants (TBAs) in hygienic practices and treatment of malnutrition. Changes in refugee behaviour included increasing acceptance of the needs of women and girls, traditionally underprivileged categories; 11 of ARC's total health care staff complement of 27 at this time (1982) were women. One attempt at helping patients to understand treatments was the use of paper "medicine bags" for prescribed drugs with pictorial instructions, still in use in 2002—most patients were (and are) illiterate. During the interview in The Hague Dr. Zamani said:

"I used bribery to get them to send their children to school; if we were issued with dietary supplements like dried milk or protein biscuits I arranged for them to be distributed through schools in the camps".

ARC's developing health care practice—and non-health expansionist activities

In 1982, the Vienna Board designated Dr Zamani "Medical Supervisor" i.e. manager of the health work. From 1982 onwards, ARC's Annual Reports contain a section on health work, until in 1990 this began to be published as a separate document. The section of the 1982 Annual Report of ARC concerned with health lists varied activities:

- MCH, with a goal of first contact at latest the seventh month of pregnancy
- TB control programme
- infant care including immunisation, malnutrition treatment using dried skimmed milk, iron supplements

- special Health Education events on topics such as boiled water, use of soap, danger from flies
- home visiting for health education and follow-up
- insecticide spraying, pond in-fills

The 1983 Annual Report records construction of the first fixed BHU, adjacent to Baghicha camp. The design (by Austrian consultants) took into account the cultural practice of segregating the sexes. It also allowed for possible adaptation for use by the local population after the refugees returned to Afghanistan, perhaps assuming a transfer of management to GOP Health Department. A second specially constructed BHU followed later, adjacent to Gandaf camp.

Allocating specific responsibility for health care work to a qualified medical professional, Dr. Zamani, freed the Peshawar Office of ARC to explore other avenues of work. Gradually it set up other projects not immediately concerned with health care:

- a Sanitation and Basic Health Team which took on some of the work done by DACAAR (1982)
- three Technical Training Centres providing courses in motor maintenance, building skills etc. (1983)
- a Sewing Project for women (1983)
- a small Employment Bureau to help refugees find work (1985)
- an Assistance to Skilled Refugees Project supplying tools and equipment, also to help in the search for work (1985)
- a Training Section concentrating on English language teaching (1988)
- inside Afghanistan, a Rural Development Project working on agriculture, animal husbandry, bee-keeping etc. (1986)

My notes on the relevant Annual Reports record the start of these new enterprises, but none was located in or closely linked with the two camps to which ARC supplied health care. The new projects were all managed from the Peshawar Office, the individual Project Co-ordinators (managers) being based there. The many different locations of these diverse Projects created logistical problems. Some new initiatives were later transferred to other NGOs, e.g. the sewing project to DACAAR, the Danish refugee agency. Prof. Reder and Wolf Zacherl said in March 2001 that the Vienna Board were in general sympathetic to the new projects as natural and related developments, because all of them fitted with the emergent goals of development in preference to relief, and preparation for the expected

ultimate return to the homeland. Both men thought some of the new projects were conceived as a result of pressure from the refugees themselves, who saw them as a form of resistance to the Soviet-supported regime in Afghanistan during the 1980s, especially the cross-border Rural Development Project started in 1986. They said the Peshawar Office started this last without the Vienna Board's knowledge or sanction, provoking anxiety on the Board's part about its ability to control work in the Peshawar Office.

Changing relationships and changed status

Prof. Reder and Wolf Zacherl considered that the Vienna Board itself worked hard and successfully at mustering support from diverse sources, including the Austrian government. As funding from voluntary sources gradually diminished, the Board contacted other donors including Brot für die Welt, Noraid, Oxfam and NOVIB, which all agreed to fund the newer projects on a 3-5 year plan basis. The Austrian Chancellery assumed financial responsibility for the health work in the form of a block grant. At first this was channelled via Institut für Internationale Zusammenarbeit (IIZ), later through the Austrian Association for Development and Co-operation (a d c Austria). This award, to start in 1985 as recorded along with the negotiations with other donors in the 1984 ARC Annual Report (AR 1984: 7) marks the specific designation of the health work as ARC's "PHC Project". 1985 also marks the Vienna Board's first "Donor Conference" in Vienna. Gerd Kellermann, Managing Director of a d c Austria, who started his development aid career with ARC in Peshawar, was also interviewed along with Prof. Reder and Wolf Zacherl in Vienna in March 2001. All three acknowledged the growing sphere of influence and wider perspective of ARC as an emerging umbrella-type NGO by the mid-1980s, while it still retained the allocated responsibility for health care provision as it had done from the start.

This initial phase of ARC and its health work appears characterised by intense activity, firstly by the Vienna Board as the initiator, publicity agent, fund-raising body and resource-finder (e.g. the visiting deputations and medical/architectural/educational consultants). Secondly, the Peshawar Office was very active as the on-the-ground implementer, net-worker and pioneer. Thirdly, at the PHC Project the change from mobile stopgap pills-and-injection practice to two fixed stations provided an improved organisational base with a potential for consolidation. This transition also seems to have stimulated questions (and actions) on the nature of the service, questions being simultaneously addressed by the UNHCR/GOP Afghan Refugee Health Programme in its promotion of the Primary Health Care strategy.

The second phase 1985-1989: consolidation of the ARC/PHC Project

To some extent 1985 is an arbitrary choice of date, for consolidation was a gradual process. For instance, the creation of fixed BHUs in 1983/4 probably qualifies as a factor in consolidation, but during this second and apparently more settled phase of ARC's "PHC Project", some expansion also occurred. The 1986 Annual Report records the start of a mobile service to Kagan camp, which is actually nearer to Peshawar than the other two camps of Baghicha and Gandaf. Later this service operated from temporary premises within the camp, until in 1988 a third BHU was constructed adjacent to the camp (ARC Annual Report 1988: 10). Kagan camp is close to the cluster of small local Pakistani hamlets usually referred to as Kagan village—it lies just across the main road. Its siting made it an obvious candidate for inclusion in the PHC Project, suggesting some geographical consolidation.

A separate office for the PHC Project

The diversifications and pre-occupations of the Peshawar Office and the allocation of health care responsibility to Dr. Zamani probably had some effect on the gradual distancing during the later 1980s of the health work, facilitated in 1989 by opening a PHC Project Office in Mardan. Mardan is nearer by about an hour's drive to the three camps than is Peshawar—only half-an-hour from Kagan camp. This office took over health care day-to-day administration and finance, and enabled closer supervision of the ARC/PHC Project. Dr. Zamani as Medical Co-ordinator was based in the PHC Office in Mardan (unlike the other Project Co-ordinators), attending regularly at ARC Main Office in Peshawar as well. This distancing and apparent relegation of health work to project status does not seem to have diminished Dr. Zamani's senior standing and influence at the ARC Office in Peshawar, in spite of ARC's penetration into other non-health-oriented kinds of work. He accompanied the Peshawar Director to ARC's major "Donor Conference" in Vienna in 1985 (Annual Report 1985: 2). The Vienna Board authorised and funded his attendance at specialist post-graduate courses in Austria in 1984 and in the UK in 1987 (Liverpool and London).

More external consultant comments—towards consolidation?

My notes on ARC's 1986 Annual Report record positive comments on the PHC Project by another visiting consultant, Dr. Arne Saeterhung, particularly on the recording system, the decrease in TB, and the extension of the service to Kagan camp. Another visitor, Dr. Bernard Faliu, in his Evaluation Report of October 1989 remarks on PHC Project staff's willingness

to learn, and also notes that patients seem to understand the importance of prevention, with decreased demand for pills and injections.

A stabilised staffing structure

ARC/PHC Project staff were almost all Afghan, and almost all resident in the camps they served. Exceptions were the LHVs, formally trained Pakistani midwives/health educators with no equivalent in the refugee population (nor in pre-war rural Afghanistan), and other specialists such as the Malaria Control Supervisor, also Pakistan-trained. The necessary two or three administrative staff in the Mardan office of the PHC Project were Pakistani (ex-army) in the absence of suitably qualified and experienced Afghans.

According to the Annual Report, in 1985 the two ARC/PHC BHU teams each consisted of the following salaried staff :

Male	Female
Doctor (Team leader)	Doctor (when obtainable)
Nursing Assistant	Nursing Assistant
1 Pharmacist (or "Compounder")	2 LHVs (qualified midwives, Pakistani)
1 Lab. Technician	2 <i>Dais</i> (older refugees, experienced traditional birth attendants)
1 Vaccinator	
1 Malaria Supervisor	
1 Driver/Milk Distributor	
1 Registrar/Clerk/Health Educator	
3 Supervising CHWs	
1 Chowkidar/Janitor/ Helper	

Additionally, there were unpaid volunteer health workers, all refugees living in the camps:

- 20 volunteer male CHWs trained by Dr. Zamani and active in each of the two camps, responsible to a Supervising CHW.
- 30 Traditional Birth Attendants (TBAs) already active in each camp trained in hygienic practice, using SCF(UK) methods/curriculum.

Vans used for the original mobile clinics had been replaced and added to by other larger vehicles capable of transporting patients, staff, equipment and supplies.

With minor changes, and with additions to vehicles, paid staff and trained volunteer numbers (a third team staffed Kagan BHU in 1988), this was the basic staff/resources pattern for the next fifteen years until year 2000. ARC/PHC BHUs were open 8am until 2pm five days per

week. There was no in-patient care. After hours and at weekends patients had to seek alternative care from a hospital or a private doctor; but as early as the Annual Report of 1982, it was claimed that records had already begun to show that emphasis on prevention and health promotive work justified the movement towards a public health approach (my notes on this Report give no details).

Dr. Zamani remained in charge of the PHC Project until the events of late 1991 outlined below. ARC retained its partnership status with the UNHCR/GOP Afghan Refugee Health Programme. This enabled access to all practical support in the form of training and refresher courses on control of endemic diseases such as malaria and diarrhoeal infections, supplies of vaccines and equipment for cold chain maintenance, drugs for TB control etc., all channelled through the Refugee Health Programme as the official central agency in NWFP, managed by Project Director Health (PDH) in Peshawar.

Activity in this second phase, while it did extend health care to the population of Kagan camp, was characterised by stabilisation—literally, in that health care was provided from purpose-built BHUs, and the additional target population of Kagan camp was on the same main road as the other two camps. External consultants' comments are less pre-occupied with such basic matters as cleanliness, and mention greater understanding by patients. BHU teams acquired a standardised form: the ARC/PHC Project became a health care service for refugees in three camps, staffed largely by refugees from the same camps. A PHC Project Office in Mardan, while enabling health care administration and supervision, also emphasised geographical and functional boundaries, and probably helped a feeling of self-containment to develop at the PHC Project.

The third phase 1990-1994: changes, crises and resolution

The early 1990s were times of dramatic, indeed traumatic change for ARC, and for the PHC Project. All developments and changes at ARC and its projects took place during this 1990-94 phase against the background of continuing turmoil inside Afghanistan, in spite of the Soviet withdrawal in 1989. Peshawar hosted an "Interim Afghan Government", as well as many small Afghan NGOs and numerous groups with different factional affiliations—a persistent feature of Afghan political life, whether inside Afghanistan or in Peshawar, often associated with threatened or actual violence.

Continued development and training work at the PHC Project

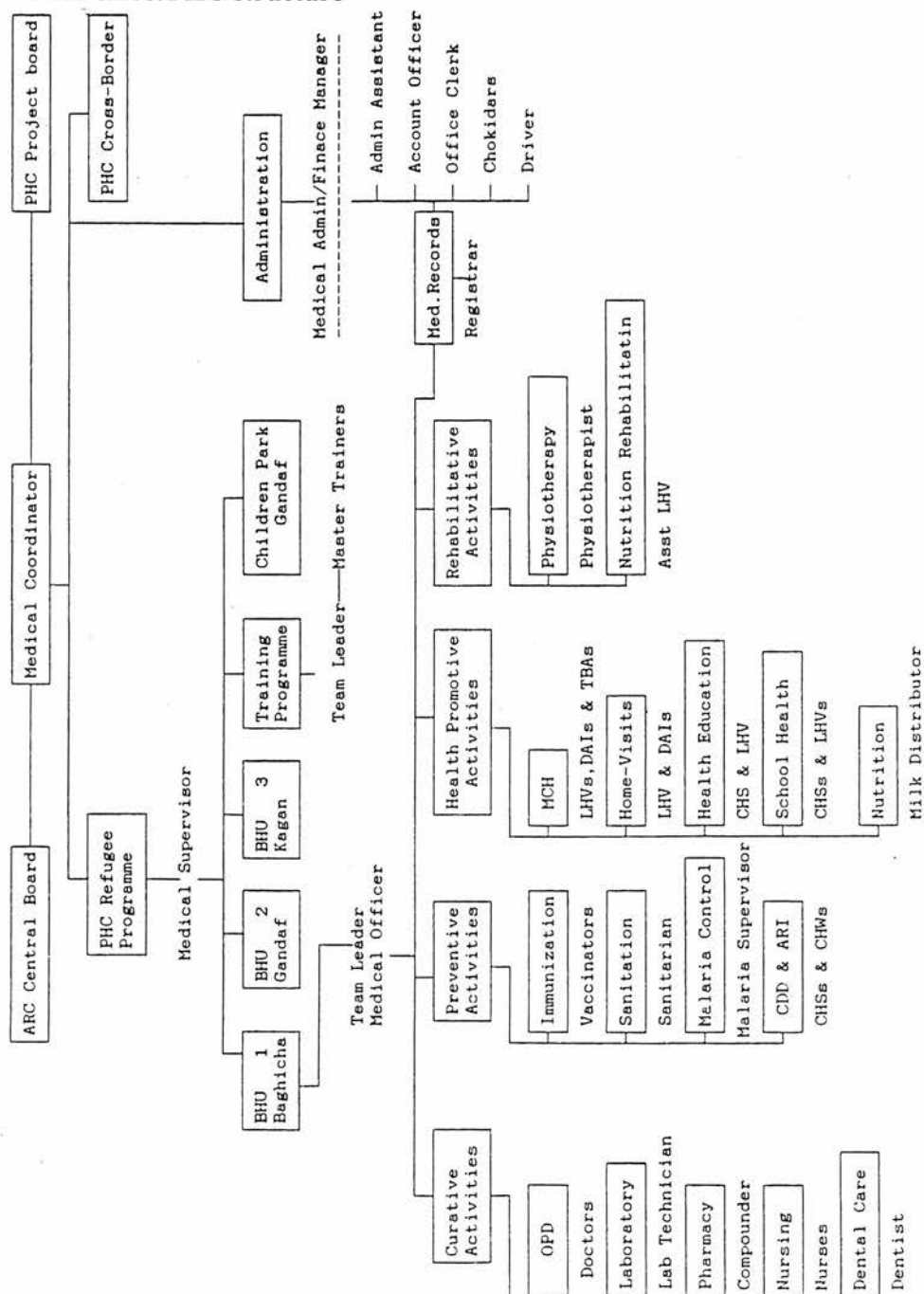
The first separate Annual Report for the ARC/PHC Project, produced for the year 1990, summarised its progress towards regular work patterns in three BHU Teams serving three camps (see Charts 3.1 and 3.2 for the structure of the PHC Project and the organisation of activities/Programmes by the year 1990). This Report gives the total number of refugees in the three camps as 31,000, probably a more accurate figure than earlier estimates. PHC Project activities were now described as formal "Programmes".

Training activities expanded, leading to the opening in 1991 of the PHC Project's Residential Training Centre in Mardan, offering qualifying courses for men as Lab. Technicians, Vaccinators and Malaria Supervisors, and later Dental Assistants. Apart from requirements for refugee health care in Pakistan, these courses were intended to provide manpower for reconstruction on return to Afghanistan. They were open not only to ARC/PHC staff but to trainees sent by other organisations; Médecins sans Frontières as external examiners developed a close relationship with the ARC/PHC Project. Visual aids and teaching materials tended to be directive and rule-based, devised for specific task-oriented jobs. Several of the 75 staff of the PHC Project completed more than one training (men only), e.g. a malaria supervisor could also work as a nursing assistant, a community health supervisor could function as a sanitarian, so that some flexibility was possible and work was less affected when problems arose.

Staff turnover especially at senior level continued, as I noted from the 1987 and 1988 Annual Reports, but it is not clear whether it refers to the PHC Project or to ARC in general. As manager (re-named "Medical Co-ordinator") of the Project Dr. Zamani had at first done much of the training himself, but in due course several staff members acquired sufficient experience for him to promote them to trainer status. In addition to the new courses at the Residential Training Centre, training of CHWs and TBAs continued. Attitudes to women's mobility appear to have relaxed sufficiently for training of TBAs—generally older married women—to take place at the PHC Office in Mardan. Social norms dictated that they were transported there and back daily—a residential course would not be culturally acceptable

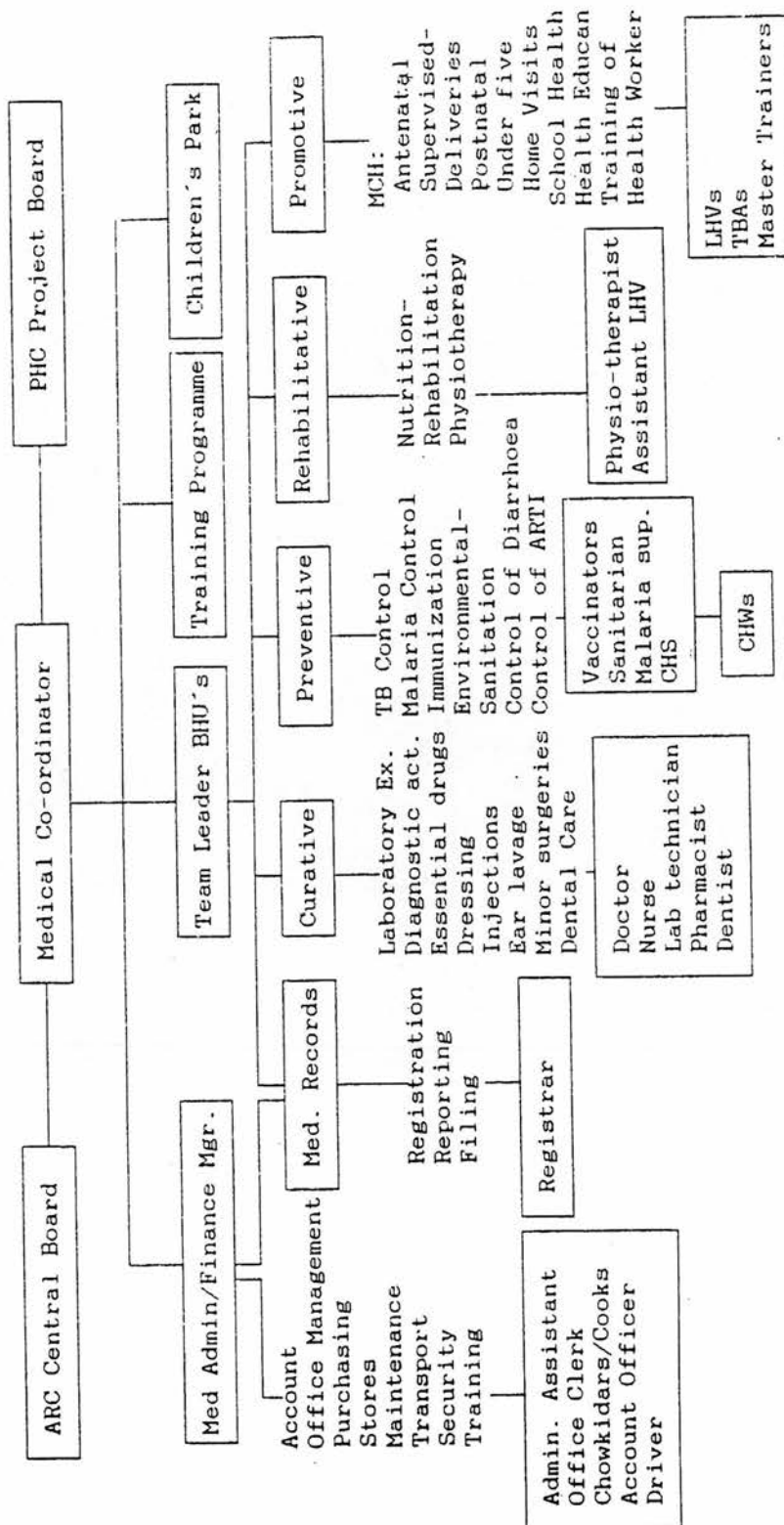
As a manager, trainer and author of a Pushtu translation of David Werner's *"Where There Is No Doctor"*, Dr. Zamani was recognised as an influential figure outside ARC—by other NGOs, as was said by a senior member of SCF staff in Peshawar (MMP Journal March 1992). He also co-authored a booklet on primary health care *"Prevention is Better than Cure"*. Within the Project, he insisted on rigorous supervision and record-keeping, as testified by project staff when MMP and JSP arrived in August 1991 during Dr. Zamani's absence on a management course in The Netherlands. For example, each BHU office

Chart 3.1 ARC/PHC structure



Source: ARC/PHC Annual Report 1990

Chart 3.2 ARC/PHC Organisation of activities



Source: ARC/PHC Annual Report 1990

maintained staff and patient attendance registers, detailed monthly reports had to be submitted on each area of work e.g. number of malaria slides examined, birth weights of babies, follow-up of clinic defaulters, etc. Dr. Zamani's practice was to pay frequent visits of inspection to each BHU, but he delegated little except in the area of training (personal observations in 1991).

A new phenomenon at the PHC Project

The opening of the purpose-built Kagan camp BHU in 1988 had stimulated interest in the PHC Project by villagers from the hamlets across the road from the camp. They began to seek treatment at the new BHU, and by 1990 between two and four thousand of them were said to be attending (ARC/PHC Annual Report 1990: 2). They were provided with basic curative care only, so as not to prejudice the service to the refugees, but there is no detailed information on the proportion of villagers' attendances. The Programme Officer (a lady doctor) of the GOP/UNHCR Refugee Health Programme said at interview in Islamabad in March 2001 that this use of refugee facilities by locals was not unusual, particularly in remote areas under-served by the GOP's own system. She said there was no formal agreement about this—*"it just happens"*—and that conversely, refugees sometimes made use of GOP BHUs: this behaviour appeared to depend on accessibility and convenience, she said.⁴

Leadership change at ARC Peshawar

General management of ARC continued at the Peshawar Office. In spite of the newer ARC projects having their own offices under the same roof, integration between them did not develop, except for occasional practical co-operation on transport of supplies or personnel. Visitors from Vienna (e.g. Wolf Zacherl in the 1987 Annual Report) had remarked on the PHC Project as the most effective of ARC's enterprises, but expressed anxiety about the dimensions, fragmentation and rate of increase in ARC's activities overall—in 1990, 230 staff altogether and a total expenditure of Pak Rs 37.8 million (see Charts/Graph 3.3 and 3.4 for staffing and expenditure of the health care work 1980-2000).

The turbulence and factionalism of Afghan politics which spilled into NWFP and Peshawar meant that in common with some Afghan personnel of other NGOs in Peshawar, the Director of ARC, Nassim Jawad, had security problems. A series of death threats to him eventually led to his resignation in 1990, and his abrupt departure to the West.⁵ This sudden loss

⁴ The official Handbook on Management of Afghan Refugees in Pakistan (1984) states that "In order to remove any tension and conflict amongst refugees and locals, the Provincial Refugee Commissioners may extend to the local population the facilities such as medical aid, drinking water supply schemes etc. made available to Afghan refugees" (Ch.14—Discipline and Security—para 13).

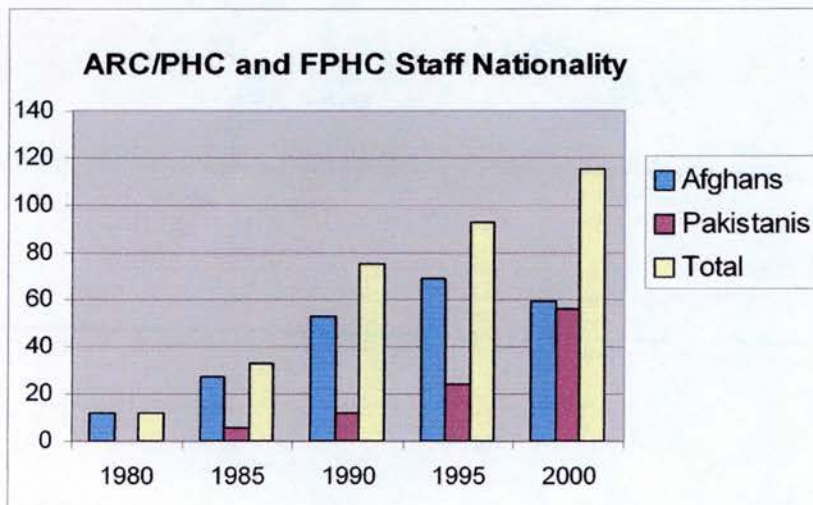
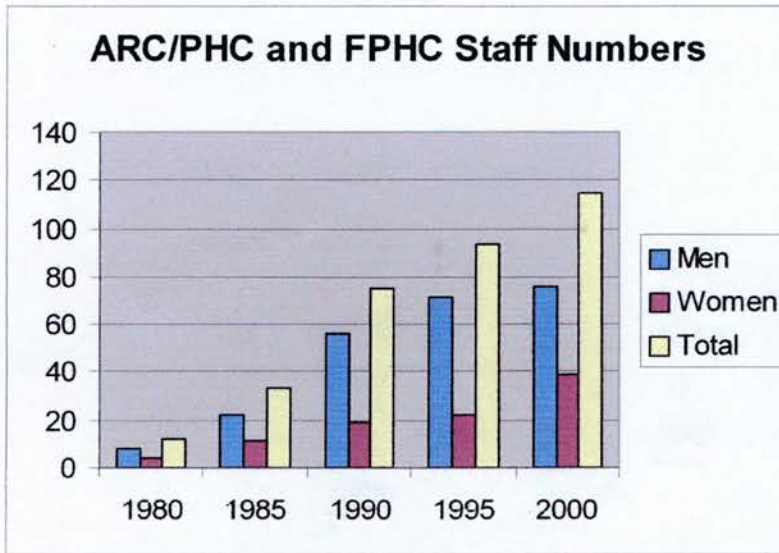
⁵ He subsequently found work as a Development Consultant. In December 2001 he was based in The Hague (telephone conversation with MMP during visit to interview Dr. Zamani).

ushered in a series of problems for ARC and its projects. After a period of uncertainty the Vienna Board promoted Dr. Zamani to the Directorship of ARC, which he accepted on condition that he retained specific responsibility for the PHC Project (interview in The Hague December 2001).

Cross-border work in Afghanistan

The range of ARC's activity noted by visitors from Austria extended into Afghanistan. Because the goal of ultimate return to the country of origin increasingly influenced ARC's planning (but not always with the full knowledge of the Vienna Board, as in the case of the Rural Development Project), attempts had been made to start BHUs across the border. One was linked with the Rural Development Project in Ghazni Province, another in Logar Province. This latter was also started without the knowledge of the Vienna Board (MMP-conversation with Dr. Janata, Chairman of ARC, in Peshawar, April 1993). Long-distance management by the Peshawar and Mardan Offices was inevitably problematic, given the continuing disruption inside Afghanistan throughout the 1990s, with "loss" of supplies, money and even personnel. These cross-border enterprises were in line with the shift in emphasis by the newer ARC donors to supporting reconstruction work inside Afghanistan in preference to work within Pakistan.

The only PHC cross-border BHU to function with some consistency was a temporary one funded by NOVIB, the Dutch agency, for about six months. This was set up as an emergency provision to help with the sudden exodus from Kabul after the collapse of the Najibullah regime in March 1992. Some of these internally displaced people camped on roadsides near Jalalabad, just inside the Afghan border. Dr. Emel Khan (at the time in charge of the PHC Project) organised a basic service with a PHC Project doctor as the only fixture—other members of this small team were seconded from the PHC Project on rotation. Supervision and management were much less problematic because road and other communications between Jalalabad and NWFP were adequate. This exercise gave a number of PHC Project staff the opportunity to work inside their home country—in fact the BHU was in the seconded doctor's family house—but they all chose to return to the camps and the PHC Project when the work finished.

Chart 3.3 ARC/PHC Staff numbers and nationality 1980-2000

1980 : 2 Mobile Teams

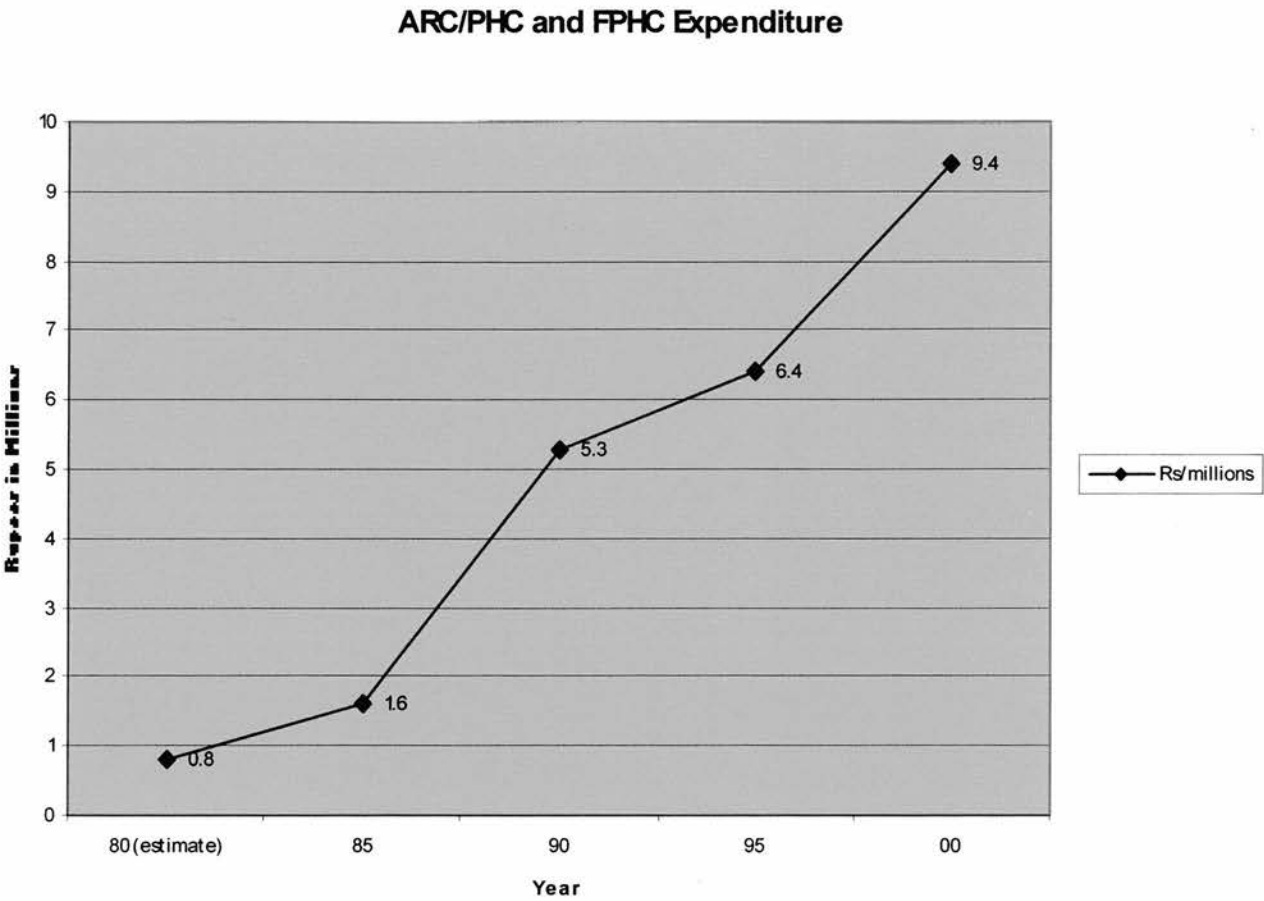
1985 : 2 Fixed BHUs

1990 : 3 BHUs + Office + Children's Park/Classroom + Training Team

1995 : 3 BHUs + Office + 2 Children's Parks/Classrooms + Training team

2000 : 6 Health Centres + Office + 3 Chn's Parks/Classrooms + HRD Unit

Chart 3.4



Source: FPHC Archives

Note: This chart does not allow for inflation. In the early 1990s, the Accountants at ARC Main Office in Peshawar, experiencing difficulty in obtaining a reliable rate, advised that any proposal for funding should allow for a 10% increase per annum. In 1991, the rate of exchange was approximately Rs 45=£1. In October 2004, it was Rs 109=£1.

Crises and crisis management

A major crisis erupted at ARC (and at the PHC Project) soon after MMP and JSP arrived in Mardan in August 1991. A few weeks after Dr. Zamani returned in October from a three-month management course in The Netherlands, he was the target of an assassination attempt, in which one of his brothers was also shot, though neither fatally. The Austrian Embassy, which maintained a close relationship with ARC, arranged air evacuation of Dr. Zamani and his wife to Vienna where they remained for over a year. A British expatriate working at the Peshawar Office took over as Acting Director of ARC. As Administrator I became responsible for the PHC Project, JSP as the only senior medical professional in ARC becoming Medical Adviser. The combination of long-serving staff experience and comprehensive routine procedures enabled the PHC Project to run on a day-to-day basis with little disruption, with the exception of the precarious cross-border health care activities. One of the BHU Team Leaders, Dr. Emel Khan, was eventually promoted to Acting Medical Co-ordinator in April 1992. Later in the same year, the Vienna Board replaced the Acting Director of ARC by setting up a Management Group in the Peshawar Office comprising the Co-ordinators of the three Projects still run by ARC—Technical Training, Rural Development, and PHC—along with the Peshawar Office Manager and another member of staff designated as "Speaker" of this group—all Afghans, except for Dr. Emel Khan, who is Pakistani. The Vienna Board instructed the Management Group to draw up plans for the gradual transfer by the end of 1995 of all the Projects into Afghanistan, including the PHC work.

The sudden death in June 1993 of Dr. Janata—founder of ARC, and Chairman of the Vienna Board—shortly after his visit to Pakistan halted any plans and exacerbated disruption in the umbrella organisation which ARC had now become. Security considerations—that is, the probability of more attacks—prevented Dr. Zamani's return to Pakistan in spite of recovering slowly in Vienna from his serious injuries, requiring repeated surgery. Doubtful about the effectiveness of the Management Group arrangement at the Peshawar Office, the Vienna Board appointed a new Director of ARC, an Afghan invited to return from Germany.

In response to these escalating problems of leadership and of the direction work was taking, the Austrian Federal Chancellery commissioned the first ever comprehensive External Evaluation of ARC from the Independent Bureau for Humanitarian Issues, Geneva (IBHI).⁶ Austria's overseas aid policy was directed towards Pakistan, and had not included work

⁶ The visiting consultants to ARC who had conducted mini-evaluations over the years and produced reports had all been engaged by the Vienna Board of ARC or were themselves members of the Board.

inside Afghanistan; additionally, the Austrian government was faced with refugee problems nearer home—the Bosnians. The Chancellery directed the External Evaluators to include in their Report a phasing-out plan for ARC, which had become more cross-border oriented, while the PHC Project work remained largely concentrated on the three refugee camps in Pakistan.

The anxiety and uncertainty in Vienna and within ARC in Peshawar had not been helped by unfulfilled expectations of mass return of the refugees to their country of origin after the Russian withdrawal and the collapse of the puppet Najibullah regime. Several large refugee camps (e.g. Munda) closed after about 1.5 million Afghans did return to their country of origin, out of the 3.5 million then estimated to be in Pakistan. There was little movement from the three camps served by the PHC Project. It had been expected; it did not happen, but in/out registers for the three camps were started and have been maintained since then, as confirmed in interviews in March 2002. From 1992 onwards the recorded turnover remained at about 4% per annum. Gandaf camp began to grow because of job opportunities at the nearby newly created industrial estate of Gadoon.

Towards resolution of the difficulties

IBHI's External Evaluation Report of 1993/4 echoed some of the concerns about ARC expressed by earlier observers, such as its rate and diversity of development, while acknowledging its ability to attract additional donors. The Evaluation Report rated the PHC Project as follows:

- *"by far the most successful project of ARC, and must not be allowed to wither away"*
- *"in the course of a few years it had considerable impact on the refugee camp population and immense improvements in the health conditions of the refugees have been achieved"* (having examined the statistics)
- *"in 1985, infant mortality had fallen from one of the highest in the world to a level below the Pakistani average (from 156 to 81) mainly due to the immunisation programme"*
- *"the (Evaluation) Team is not aware of any other refugee situation where similar results have ever been achieved"* (IBHI 1994: 93-104)

The Evaluators subsequently prepared a "Transformation Strategy" (1994) for the PHC project only, at the request of a d c Austria, the channel for the block grant from the Chancellery. The "Transformation Strategy" reiterated its positive comments on the PHC Project:

"the living conditions of the refugees had been considerably improved and even in 1985 were better than those of the host population" (1994 IBHI: 3)

It outlined several options for the future of the PHC project (IBHI 1994: 6-9):

1) Phasing out along with the rest of ARC's activities

2) Extension into Afghanistan

3) Transformation into an indigenous NGO

EITHER as an Afghan NGO to work inside Afghanistan and serve refugees in Pakistan as well

OR as a Pakistani NGO for local Afghans and local Pakistanis

The External Evaluators (Zia Rizvi and Hanne Christensen of IBHI) recommended the last option for the following reasons (IBHI 1994: 8-9):

- it would maintain the health conditions of the existing target group
- it would potentially improve the health of villagers near the camps by building on the relationship already forged with the local population, particularly evident at the Kagan BHU
- it would make political sense by reducing the imbalance between the health status of the refugees and the local people
- the project could continue to train volunteers and middle grade health professionals as it was doing already, and in this way would still be contributing to reconstruction in Afghanistan.

At a "Planning Forum" in Peshawar of senior PHC staff, both Afghans and Pakistanis, along with Zia Rizvi, principal Evaluator, Gerd Kellermann, Managing Director of a d c Austria, and MMP and JSP (1st May 1994) PHC Project senior staff viewed with apprehension an additional suggestion that a rural development approach be built on to the health care service. They objected partly because of their lack of relevant expertise, and partly because of the perceived problems of over-expansion experienced by ARC (Minutes of Planning Forum, JSP May 1994).

Acting on the advice of the Evaluators, the Vienna Board took the decision to close down ARC and opted for the continuation of the PHC work, but without the cross-border health care activity. a d c Austria agreed to continue the block grant to the PHC Project for two years until new donors could be found to support what was to become a new free-standing Pakistani NGO—"Frontier Primary Health Care"—FPHC. Closing down ARC was dramatic and stressful for the Vienna Board, for ARC staff, who became jobless, and for PHC Project

staff, perceived by some as unduly favoured.⁷ A small "rump" of former ARC staff contrived to maintain a presence in Peshawar and to find finance for some cross-border work, but contact with the PHC Office in Mardan dwindled and ceased.

This turbulent period drew to a close during the later months of 1994. a d c Austria had assumed temporary oversight of the PHC Project after the official closure of ARC and the disbanding of the Vienna Board, and re-engaged me (the two-year VSO commitment having finished in 1993) as Development Adviser with the following remit:

- 1) to set up all administration required for the proposed new NGO
- 2) to help implement a plan of expansion into the local Pakistani villages in the neighbourhood of the three camps
- 3) to find new donors to replace a d c Austria, which planned to provide funding for another two years only, and on a diminishing basis.

The fourth phase 1995-2000: FPHC—the new NGO

The idea of a Pakistan-based NGO was acceptable to PHC senior staff. They had already discussed ways of countering the potential loss of human and material resources if the Project were to transfer in its entirety to Afghanistan, as had been envisaged by the Vienna Board for the whole of ARC in 1993. Such a move would have affected not only local villagers, but also the apparently stable population of the three camps. Speculation about the viability of the proposed NGO and of their livelihoods provoked tensions and anxiety among staff, most of whom were Afghan. Many had strong feelings of loyalty to ARC and had no experience of any other organisational setting. In fact, no staff member left, although the award of severance pay⁸ to which many were entitled as long-serving employees of the former ARC enriched them considerably by local standards, and could have enabled them to leave the camps and/or start new enterprises.

New NGO "business"

Registration:

Following research and the devising of a Memorandum of Association and Rules and Regulations setting out aims and objectives etc. all as required by legislation, the new NGO

⁷ The only other ARC Project to survive (which acted as a precedent for the "PHC as NGO" option) was the Sanitation and Basic Health Unit which had separated from ARC in 1992 (i.e. before the major crisis) and had attained independent NGO status as PAK Community Development Project (PAK-CDP) in order to do more work in Pakistani villages; most of its staff were Pakistani, not refugees.

⁸ Like many NGOs, ARC and its projects offered only annual contracts of employment and no pension scheme, but a "severance pay" system existed which provided a lump sum to departing employees, calculated on salary level and length of service.

was registered as the legal entity "Frontier Primary Health Care–FPHC" under the Societies Registration Act of 1860, as from January 1st 1995 (Registration No. 5972/5/2617). For a statement of FPHC's Objects see Figure 3.3. Legal advice was that this Act allows more autonomy to NGOs than other legislation available for the formation of voluntary bodies. Dr. Emel Khan was appointed Director. The new committee was a Board of Governors consisting of nine people local to NWFP. Most were professionals in medicine, law, education and banking; two were women. The President (since deceased) was Khan Abdul Ali Khan, a much respected senior administrator and son of the late Abdul Ghaffar Khan ("Badshah Khan"), a legendary figure whose advocacy and leadership of passive resistance to British rule had earned him the nickname of "The Frontier Gandhi".

Extension:

FPHC staff proceeded with extending work into the villages, at first in Kagan, building on the existing positive relationship with the villagers—no help was needed from MMP or JSP with this aspect. JSP worked as a volunteer Adviser during our (mostly) joint commuting to Pakistan 3-4 times each year 1994-1998, doing no clinical work but revising the drugs list, examining statistics, helping with writing reports and visits, while MMP concentrated on revising Conditions of Service and job descriptions etc. appropriate to the new NGO.

Donors and funding:

Money became less available after the Cold War ended in 1992, when many organisations left Pakistan. FPHC, like other NGOs, had to enter the competitive funding market, in contrast to the relative security since the mid-1980s of the regular block grant from Austria. The infant FPHC was at risk of declining and even disappearing unless adequate income could be raised. Searching for new funding from various donors (often specific in their conditions of award) became an on-going pre-occupation. An NGO with a declared non-discriminatory policy was unacceptable to donors committed to either refugee or Pakistani causes but not to both. However, the search raised the profile of the new NGO and gradually slewed it round towards a new constellation of relationships with agencies having broader humanitarian interests (e.g. CIDA, the Canadian development agency; Family Planning Association of Pakistan; William Adlington Cadbury Trust (a Quaker fund in UK); The Asia Foundation (TAF) an American organisation; and the British Council.

Figure 3.3 Objects of FPHC

REGIS- TERED OFFICE	II.	The registered office of the Society will be situated at Nissata Road, (P O Box No. 52) Mardan, in the North West Frontier Province of Pakistan, or at such place as may, from time to time, be determined by the Board of Governors.
OBJECTS	III.	The object for which the Society is established on a non-profit basis, is the improvement of the health of the population of various villages, initially in the Mardan/Swabi Districts, but in due course the Society may extend its area of operation, all in accordance with the World Health Organisation's definition of health as "a state of complete physical, mental and social well-being".

In particular :-

- 1) To extend and develop in neighbouring Pakistani villages the range of preventive, promotive and curative health services currently provided by the Primary Health Care Project of the Austrian Relief Committee for Afghans in the refugee villages of Baghicha, Gandaf and Kagan.
- 2) As an essential element in the extension of service, to recruit and provide training for local people, both male and female, as community health workers.
- 3) To give special emphasis to the needs of women and children, by further developing programmes devoted to the prevention of illness and promotion of health, namely care before, during and after delivery, child health, immunisation, school health, health education; and also to develop a family spacing programme.
- 4) To further develop specialist programmes for prevention and treatment of endemic conditions, such as diarrhoea, malaria and tuberculosis.
- 5) To provide diagnostic and curative services, including referral to hospital in individual cases.
- 6) To develop programmes of rehabilitation, both physical and mental.
- 7) To maintain precise records and statistics of each activity, to assist with monitoring and evaluation.
- 8) To develop and promote Frontier PHC as a model of services, from which other organisations in the health field can learn.
- 9) To co-operate with other agencies in all ways necessary for the further development of the service.

Source: Memorandum of Association of FPHC 1995

And for 1996/7 FPHC was awarded the maximum grant of Pak Rs 7.5 million under the Participatory Development Programme of the Social Action Project of the Government of Pakistan (SAP/PDP-1st Phase). FPHC in its time as a project of ARC had been little known outside the refugee-oriented NGO community in Peshawar. Potential new donors tended to be Islamabad-based. The SAP/PDP 1 award signalled a new relationship with GOP; the Assessors said during their visit to FPHC:

"This is an organisation which must not be lost" (conversation between Assessors and Director FPHC, MMP and JSP in September 1995).

Moving into the villages

From the beginning of 1995, in accordance with its objectives of extension into villages and non-discrimination between local people and refugees, FPHC:

- began to make the full range of preventive and health promotive programmes available to Pakistani villagers
- began planning a new BHU in the village of Gandaf, near Gandaf camp (first Annual Report of FPHC, 1995: 23)
- introduced a "patient contribution" of Rs 5 per head per outpatient visit; refugees as well as villagers accepted this, following discussions in the camps and villages between FPHC staff and elders (FPHC AR 1995: 2). All programmes continued to be free. The patient contribution was raised to Rs 10 per head in 1996 (FPHC AR 1996: 3).
- made a small charge to "guests"; these were people who were not resident in FPHC's target area, who in some cases travelled long distances to seek treatment at FPHC, as noted in the Evaluation Report of 1993/4 (IBHI 1993/4: 32; AR 2000:6). No special records of these people were kept.

Population picture and practice change

From 1995-2000, there was no sign of return to Afghanistan by FPHC staff, nor of any substantial movement by residents of the three camps, though from time to time individuals made trips across the border to attend to business—some still had land and/or family members in Afghanistan. Chaos within Afghanistan persisted in the form of civil war, until the Taliban imposed its superiority in 1996. By 1995, over 50% of residents in the camps served by FPHC were people born in the camps. Surveys by FPHC staff of villages in the Kagan area

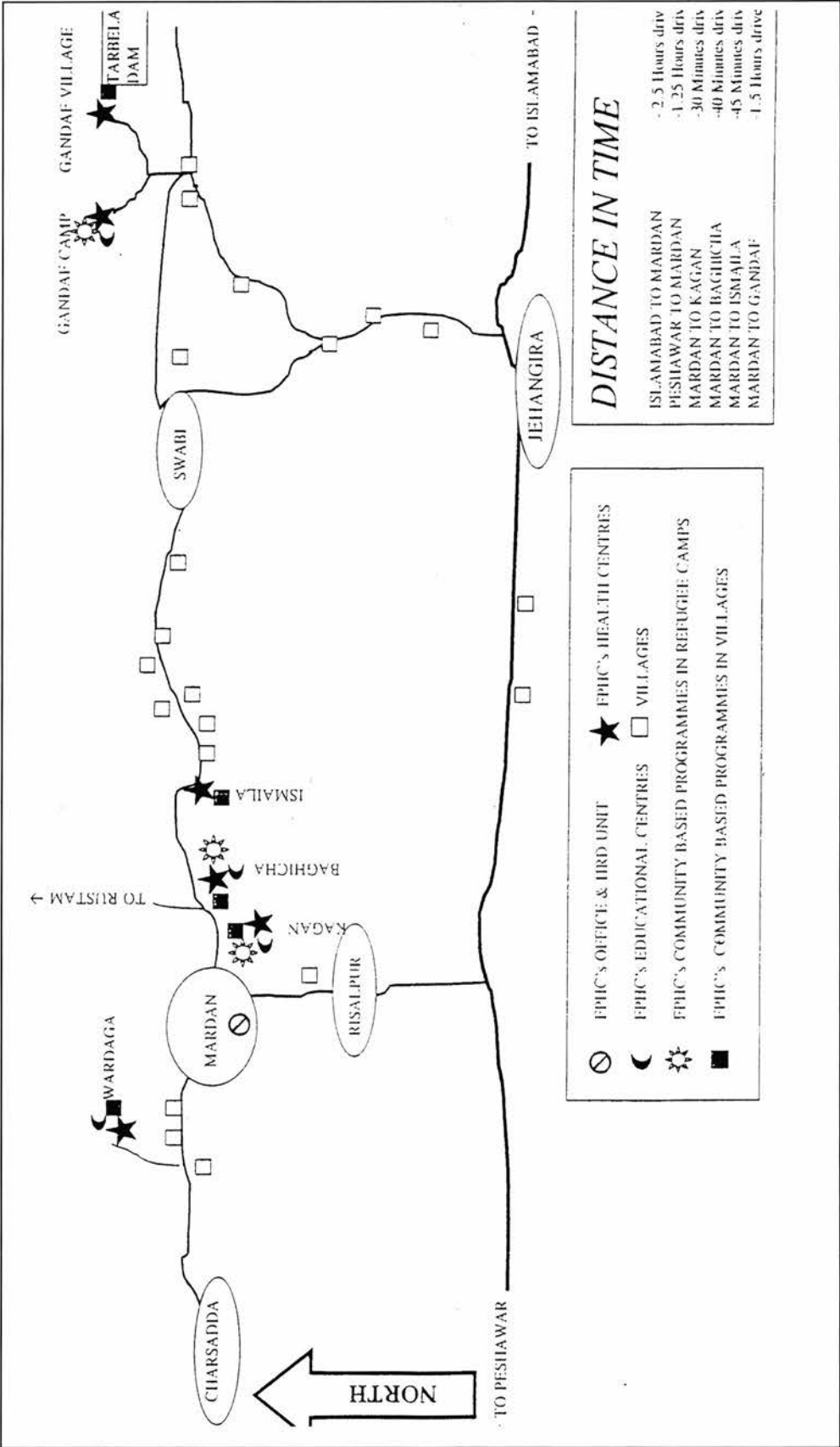
(FPHC Annual Report 1995: 6) showed that the population structure of these camps was very similar to that of the villages, i.e. approximately 26% men, 25% women and 49% children (0-15 years)—apparently an indication of the settled nature of the camps.

Formal registration of villagers as patients began in 1994 in anticipation of the new non-discriminatory policy, according to the Final Annual Report of ARC/PHC (1994: 25). 10,000 Kagan villagers chose to register. Freed from responsibility for BHUs inside Afghanistan, FPHC initiated changes in the pattern of its activities within NWFP:

- it closed the Residential Training Centre in Mardan, and trained more volunteer health workers (men and women) using premises made temporarily available by villagers (FPHC AR 1995: 19). Previously, volunteers were refugees working only in the camps.
- it used Participatory Rural Appraisal (PRA) when another village (Wardaga, in Charsadda District, outside the original target area) asked FPHC to provide a health facility. The outcome was that Wardaga villagers requested that this Health Centre would concentrate on Mother and Child Care (MCH). The Asia Foundation (TAF) provided training in PRA and later, funding for this Health Centre (AR 1996: 3).
- it began to respond to requests from small NGOs (or CBOs—Community Based Organisations) for help with training volunteer health workers (AR 1996: 20)
- it constructed two more Children's Play Parks with classrooms for girls, one each adjacent to Baghicha (started 1994) and Kagan camps (1996), using more money donated by St. Johann School in Austria and camp labour. The Kagan class admitted village girls as well as refugees; a waiting list started as soon as the class was full.

From 1995-2000, the clinical Programmes provided at FPHC continued without any substantial difference. Attempts to start Mental Health and Early Education (pre-school) Programmes in 1996/7 failed because of recruitment and funding difficulties, though proposals were drafted. In 1997, FPHC opened another new Health Centre in the large (pop. 20,000) village of Ismaila, near to Baghicha camp (see below) bringing the total number of FPHC Health Centres to six. By year 2000, the patient population registered and eligible to use FPHC services had grown from the original 30,000 refugees in three camps to a total of 105,000, including the original refugee group. Salaried (i.e. trained and experienced) staff had increased to 115 (AR 2000: 6) a larger proportion of whom were Pakistani than in earlier years—refer to page 50 for Afghan/Pakistani staff ratio and see Figure 3.4 for FPHC units in 2001.

Figure 3.4 Diagram of FPHC Health Centres;



Source: end-paper FPHC Annual Report 2001

Change promotes further changes

Decentralising to peripatetic working in village locations as indicated above seems to have influenced both patient behaviour and FPHC practice:

- in Wardaga, the PRA experience stimulated village people to pressurise government departments to provide a telephone line and carry out road repairs (field notes 2001)
- Dr. Wagma Reshteen, the senior lady doctor/manager of MCH at FPHC introduced local "Breast-feeding Groups" (with no objection from men) which sometimes led to action. For example, a women's group in Wardaga village insisted on improved staff attendance at a local girls' school, set up a book-collection scheme (the mothers themselves were illiterate) and continued to monitor the school by visiting (field notes 2001).
- management obtained via patient group discussions information supplementary to that gathered by methods previously considered adequate. For example, during home visits, LHVs routinely checked that women received ferrous sulphate tablets, but in informal groups some women revealed that they were not taking them (field notes 2002).
- groups in villages, including men's groups, began to be used for health education as well as home visits, talks or tape-recordings to waiting outpatients at Health Centres. "Family spacing" –the preferred term–could be discussed, but women showed more interest than men (group interviews with male and female patients in camps and villages March/April 2001). The Annual Report for 2000 (p.5) notes that it can be difficult to get groups going, because participants expect curative services rather than health information. This refers to villagers rather than refugees, who had many years of health education.
- with help from CIDA's "Women in Development Programme", gender training was started for FPHC staff but not with patient groups—a difficult subject in the local culture (field notes 2001, 2002)

Another development—Government interest

In 1995 FPHC submitted a formal proposal to work with the Family Health Project in Peshawar (a conjoint exercise of SCF (UK), the World Bank and the Provincial Government's Health Department) but this made no progress. In 1996 the District Health Officer (DHO) Swabi District of GOP's Provincial Health Department approached FPHC for

help with immunisation of village children in his District, for which GOP provided the vaccines (AR 1996: 37). This arrangement included in later years Ismaila, Gandaf and Baghicha villages (AR 1999: 2). FPHC also collaborated in GOP's TT (tetanus toxoid) crash programmes and polio eradication campaigns, but without acknowledgement from or involvement by senior Health Department level. FPHC negotiated with DHO the transfer of a disused GOP BHU in Ismaila village as a FPHC Health Centre for that village; villagers voluntarily constructed a shelter for waiting patients (AR 1998: 8). Following the coup by General (later President) Musharraf in 1999, the new Health Minister for NWFP, Dr. Shaheen Sardar Ali (the first female Minister in any NWFP Department) visited this Health Centre in 2000 and initiated discussions on ways of promoting co-operation between GOP and FPHC (AR 2000: 5). Her successor, Dr. Meher Taj Roghani, formerly a professor of paediatrics at Peshawar University, maintained the interest (field notes 2002).

Evaluating the new NGO: 1998 and 2000

Towards the end of this period of intense activity and change, in order to assess the effect of the transition to new identity and status, FPHC asked Zia Rizvi of IBHI to return five years after his seminal Evaluation Report and Transformation Strategy of 1993/4. In 1998 he and a Pakistani public health specialist produced an Evaluation Report which recorded positive comments on FPHC as a service-delivery organisation:

- continuity in basic structure and leadership
- use of advisers
- further potential as training/support agency to small NGO/CBOs
- efficient data base management

but he suggested that better use could be made of the last for

- assessing impact
- strategic planning
- research.

He also noted that the Board of Governors was not very active and in need of education to help them become effective policy-makers (IBHI 1998: 6-10).

The Evaluations of 1993/4 and 1998 had been developmentally rather than clinically focussed.¹⁰ At the request of CIDA, in the earlier part of 2000, a female paediatrician, Dr. Shabina Raza, undertook a more clinical exercise under the supervision of her professor (at

¹⁰ In 1997 a medical visitor to FPHC had suggested that the almost total prevalence of anaemia was a reason for discontinuing haemoglobin tests in pregnancy and instead issuing iron tablets as a matter of course (MMP Journal) but this was not acted upon.

that time, Dr. Meher Taj, above) using techniques such as patient/exit interviews, commenting as well on FPHC's team-work, administration and relationship with communities. She made a number of recommendations on clinical matters, but in general her assessment was positive. At a strategic level, she emphasised the following needs:

- management training for Team Leaders
- better liaison with hospitals
- further promotion of family planning
- more active work in the provision of safe water and sanitation)¹¹
(Raza 2000: 11,14, 23,35)

Later in year 2000 conjoint work started with CIDA, the Khyber Teaching Hospital in Peshawar and FPHC to set up a combined project on MCH, with two visiting Canadian medical consultants engaged to help FPHC to start examining its own research potential (field notes 2001)¹².

Conclusion

The global political climate of the late 1970s and early 1980s meant that Western countries (and some Arab ones) were sympathetic to the millions of refugees who fled into Pakistan following the Soviet invasion of Afghanistan in late 1979. Whether motivation was political or humanitarian, many NGOs became active on their behalf. In Austria, a group having academic and professional connections with Afghanistan responded to expressed emergency medical needs of some refugees in NWFP by founding the international NGO ARC.

The UNHCR/GOP-sponsored Afghan Refugee Health Programme became responsible for health care for refugees in camps. ARC's partnership in this Programme enabled it to move from curative medical work towards the public-health-oriented strategy of PHC as promoted by WHO according to the 1978 Declaration of Alma Ata. The leadership of Dr. A.R. Zamani was crucial, as was SCF's practical programme for training volunteer health workers from the camps—an example of community participation advocated in the Alma Ata Declaration as essential for implementing PHC.

As it became apparent that the Afghans' stay in the host country would be longer than expected—a not uncommon feature of refugee situations—a block grant from Austrian

¹¹ FPHC staff readily admitted the lack of safe water/sanitation in the villages, while arrangements in the camps were adequate (group interviews with FPHC Health Centre teams 2001)

¹² The consultants paid a preliminary visit in early 2001, but plans were put on hold after the events of 9/11 which limited international travel.

government sources replaced voluntary financing of ARC's health work. ARC's overall aim in all its projects was to prepare the refugees for reconstruction of Afghanistan, but some of these activities gradually distanced the Vienna Board of ARC from the Peshawar Office.

The change in the world political climate influenced by the withdrawal of the USSR in 1989 did not reduce turmoil within Afghanistan. Many refugees did go back to their country in 1992 after the fall of the Najibullah regime, in spite of the outbreak of civil war. Many others including most of those in the ARC/PHC camps remained in Pakistan. But western interest in Afghan refugees declined after the end of the Cold War, resulting in a depletion of resources, including finance. Many NGOs left Pakistan.

ARC stayed, but a series of internal crises re-activated Austrian interest and revolutionised planning. The External Evaluation Team of 1993/4 recognised development potential in the health project. Already semi-detached from the Peshawar Office, and able to build on local villagers' preference, the project was transformed into a new free-standing NGO "Frontier Primary Health Care" in 1995. Independence, though not without pain, may seem incremental rather than planned, but ultimately the process of separation and adaptation was more administrative than functional.

and c Austria continued to make a limited block grant, but typically the NGO has an ongoing task of seeking adequate finance for its six Health Centres, serving in year 2000 a total of 105,000 people. New leadership determined that work became more community-oriented. Group methods stimulated discussion on community needs, leading to positive repercussions among villagers (including women), who achieved some improvements in local amenities. FPHC developed new relationships, e.g. with new donors and with CBOs. Practical co-operation with middle-management of GOP Provincial Health Department began in 1995, and in year 2000, interest at senior Departmental and Ministerial level was recorded.

Thus in the twenty years 1980-2000, a relatively small international medical relief initiative for refugees evolved into a much larger public health indigenous NGO with a stated policy of providing basic health care to local people in a specific area of the host country, refugees and non-refugees.

Two external evaluations in 1998 and 2000 are in general positive about FPHC as an NGO aiming to practise Primary Health Care. Because FPHC and its predecessor claimed to implement this health strategy, it is appropriate in the next chapter to explore the concept of Primary Health Care in more detail.

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CHAPTER 4

PRIMARY HEALTH CARE (PHC):

ORIGINS AND PROGRESS, GLOBALLY AND WITHIN PAKISTAN

The last chapter, in describing the history of the health project and its development into a new independent NGO indigenous to Pakistan, mentioned influences ideological, organisational and personal which affected the NGO's health practice. Started as medical relief, the health project of ARC claimed to have become able over the years to provide Primary Health Care (PHC), a claim also made by its successor, Frontier Primary Health Care (FPHC). Deliberately retaining the phrase in the new NGO's name asserts an adherence to the concept or set of ideas referred to as PHC. This chapter is intended to explain these ideas and their relevance to Pakistan.

PHC as a concept has a history and is still developing. I propose to outline the trends and sources of thinking about health care provision which emerged during the twentieth century and formed the background to the WHO Conference of 1978. This Conference was convened in order to address the growing concern about health status and health problems world-wide. The outcome of the Conference was the Declaration of Alma Ata, enshrining the definitive statement of PHC and its promotion as a means to "Health for All by the Year 2000". This chapter addresses the strategic and tactical aspects of the Declaration, and some responses to it, including the emergence of SPHC (Selective Primary Health Care) and the shortcomings of this suggested alternative to PHC. The chapter instances attempts by various countries to implement PHC.

The later part of the chapter deals with Pakistan's health care system from its creation as a new state after the partition of India in 1947. I argue that in spite of recorded interest even before that date in the need to consider new ways of improving the health of the majority, Pakistan has failed to achieve significant overall change for the better in health and health care, especially for its rural population. I will also draw on evidence from fieldwork in 2001 and 2002 to show that Pakistan has failed in spite of repeated planning input, legislation and international practical support for schemes to aid implementation of a public-health focussed service. This failure has left the health care field in Pakistan open to agencies other than the government.

Health and health care—global views

Green and Matthias (1997: 40-41) summarise three main views of health care:

- a commodity or consumer good to be available through market mechanisms to those seeking it and able to pay for it
- a means to keep the workforce healthy and productive—the "investment" approach
- a fundamental aspect of life, not dependent on the individual's productivity or ability to pay

Green and Matthias admit that this is an over-simplification, and that it is partly dependent on the type of health care being considered—for example, free provision of some kinds of cosmetic surgery is controversial. It is however the third of the above views which is supported in the 1946 Constitution of the World Health Organisation (WHO), which proclaimed that

"the enjoyment of the highest attainable standard of health is one of the fundamental human rights of every human being without distinction for race, religion, political belief, economic or social condition".

This goal, treating health as a human right, has links with the widespread post-World War II realisation that things would (or could) never be the same again, as former colonies started on the path to independence. It implies a new global perception of health, and indeed of humanity.

At that time, it was believed that the advances in knowledge and technical expertise in western-type medicine could be employed for the general betterment of human kind. In the immediate post-war era, these seemed to offer the best chances for solutions to the major persisting health problems of developing countries (Koivusalo and Ollila 1996: not paginated). Consequently, the original phase of WHO was marked by a disease-oriented style which reflected these optimistic expectations. Certain diseases, most notably tuberculosis, venereal diseases and malaria headed the list of the most serious threats to global health. It was believed that eradication of these could be achieved by disease-specific campaigns—the "vertical" approach. Such expectations were fulfilled only to a limited extent.

The vertical approach

Malaria provides an example. WHO in its advisory role produced guidelines for its eradication, but itself had no funds and no international mandate to mount campaigns.

Responsibility for funding and implementation was therefore a matter for individual governments. Harrison (1978: 228) explains that what appeared to be a well-planned strategy against the mosquito was successful in the initial years in some of the 52 countries which adopted the guidelines; but by 1964 WHO had to admit that the international achievement while impressive, was significantly smaller than had been hoped. Africa was particularly problematic, but even elsewhere, following initial enthusiasm, difficulties encountered included:

- side-effects of DDT as an insecticide
- slow implementation (thus allowing time for the breeding of resistant strains of mosquito),
- poor capacity for organisation, including failures of leadership, recruitment and supervision for what was essentially a tedious, repetitive and exacting job.

Of efforts to tackle malaria in Pakistan, Harrison says

"By this date (1964) Pakistan had yet to launch any campaign at all in half the country" (1978: 247)

More generally, he notes problems encountered during eradication campaigns as

- difficulty in reaching remote areas
- poor reporting, even lack of interest by doctors
- tendency to call off a campaign to save money once improvement was evident, thus provoking relapse, as happened in Sri Lanka (1978: 250-251).

Harrison states that by the 1970s it had become evident that the vertical disease approach was ineffective at least as far as malaria was concerned. Eradication as a strategy had not met expectations, but it had highlighted problems which might arise if vertical programmes for other diseases were being considered. WHO settled for a policy of control as being more realistic for malaria, while research continues even today to find a vaccine.

Reality, realisation and international experience

By the 1970s, despite efforts, the picture was of increasing global morbidity. Large numbers of people were not enjoying an acceptable standard of health; and by the late 1970s nearly one billion people were living in poverty, recognised as closely linked with malnutrition and susceptibility to infection. For example, Stapleton (1975), in referring to the Third World (the term often used at the time for developing countries) mentions the high proportion of

people living in rural areas and the high percentage of young children in that population; as well as the high neo- and peri-natal death rates; he remarks specifically on

"the high death rate of children between one and five years of age—usually due to infection superimposed on malnutrition; not only unemployment but more particularly underemployment is the rule rather than the exception"

The World Health Assembly of 1974 noted

"striking disparities between and within countries, and asked the Director-General of WHO to explore possibilities for more effective action"

This request indicates some shift in outlook, a search for other ways of addressing global health and health problems. "*Disparities*" refers to the contemporary (and persisting) vast difference between standards of health and health care provision in western countries and those in the developing world, and between social groups in each of these two categories (Townsend, Davidson and Whitehead 1982:1-3). The World Health Assembly perceived an exacerbation of these inequalities—in other words, things were getting worse: the poor were (and are) the worst served, whether they are in the west or elsewhere, as Hill observed in 1997 (pp12-13).

In response to the Assembly's call, a series of national, regional and international meetings in 1977 was held in Africa, the Americas, the Eastern Mediterranean (embracing the Middle East), the Western Pacific and South Asia to address this refractory problem. Participants included politicians, health experts, representatives from WHO and UNICEF, which had a particular interest in the unsatisfactory health status of the world's children. The broad attendance included many people from developing countries. New York hosted a similar meeting for industrialised nations, and in 1978 an International Congress of NGOs took place in Halifax, Canada. The emerging theme at these meetings was primary health care (PHC).

Sources of PHC ideas

The concept was not new, and has no single origin. In western countries, while advances in modern medicine and surgery have been and still are impressive, it was the nineteenth century writings and practical work of pioneers like Chadwick, Farr and Snow in the UK, von Pettenkoffer in Germany and Shattuck and Smith in the USA which promoted the adoption of public health measures like clean water and sanitation, in the interests of the health of the majority (Guthrie 1945: 386-92). Notestein's theory of demographic transition gives credit to generally improved living conditions: better nutrition and housing have

preventive and promotive effects on health (WHO 1988: 31). The nineteenth century may seem distant, but in terms of the long history of medicine, public health measures are relatively recent and belong to modern times (Luca 1982: 2).

Other significant contributions to the development of a public health approach are also of relatively recent origin, though some have a longer history than others. For example, in China, the phrase "barefoot doctors" was not used until 1968 but their roots and the reconstruction of health care in China go back to the 1920s and 1930s (Luca 1982: 2). These workers won widespread recognition as effective agents for raising standards of health throughout communities. In India in the 1940s there was interest in creating a new kind of health worker—in effect a Community Health Worker—who would work at village level; but the idea was not developed further in India until the 1970s (Jeffery 1998: 225).

The 1970s writings of Djukanovic and Mach, Newell and Rifkin, drawing on experience and observation of successful basic health care projects in non-western countries e.g. Jamkhed in India, and others in the Philippines and Indonesia—all NGO initiatives—put the case for achievable improvements in the health of ordinary people by means of simple, inexpensive, preventive and health promotive techniques. They argued that these could be applied by unsophisticated, even illiterate people if properly trained in their use, and importantly, if they are people from the community itself.

PHC owes something to Luca's concept of "trans-national diffusion" (Luca 1982: 1). New ideas and knowledge have ways of travelling, for example via professional journals, libraries and nowadays the internet. Luca uses the phrase in regard to medical modernisation in China, but it is useful for describing the complex evolving process of new strategies in the field of health care. Another mechanism for trans-national diffusion is attendance at courses in countries other than one's country of origin, regarded as centres of excellence—or at least as sources of stimulating ideas. The Report of the Health Study Group which met in Lahore is positive about the established role of WHO as a forum for encouraging the sharing of knowledge:

"Sovereign states with conflicting ideologies meet in WHO and co-operate for the common good...it is one of the most beneficent organs of the UN" (1970: 11)

The same Report of the Health Study Group appreciates the achievements of Communist states in improving the health of their people; it also quotes the Pakistan Planning Commission:

"Health is a means of achieving rapid development and a principal goal of development itself" (1970: 5)

Within Europe, a WHO working party held in Moscow in 1973 was required to concern itself with primary *health* care rather than primary *medical* care (WHO 1973: 2). It stressed the need for a team approach by health care providers.

In 1977, the first English edition of Werner's *"Where there is no Doctor"* was published. The original publication of this handbook for basic health care workers was in Spanish, following Werner's 13 years of work in western Mexico. Of particular interest to this case study is that in Vienna, at local level, there were doctors and medical students meeting in the 1970s to discuss ways of providing health care, as distinct from those who had specific disease/technical interests, as Dr. Dörflinger told me at interview in Vienna in March 2000. Later he worked in Nicaragua, where he first saw and used Werner's *"Where there is no Doctor"* as a self-training manual as part of on-the-job learning. His Nicaraguan experience brought him to the notice of Dr. Janata, Chairman ARC's Vienna Board, and led to Dr. Dörflinger acting as a consultant to ARC/PHC in its earliest and formative phase, as related in Chapter 3.

Re-thinking

The Director-General of WHO responded to the 1974 call for exploration of other ways of tackling the world's health problems by collaborating with the Executive Director of UNICEF to produce a Report submitted to the international Alma Ata Conference of 1978. This Report ultimately formed the basis for the Declaration of Alma Ata and its goal of "Health for All by the Year 2000". The Report criticised inappropriate concentration of health resources on sophisticated medical institutions in urban areas, benefiting the privileged few, without improving the health of the overall population. It expressed concern for the social development of the "have-nots" especially those in the developing world—and it did not restrict itself to a purely medical view of health. The Report was unequivocal in its support for PHC as

"the key to achieving an acceptable level of health throughout the world in the foreseeable future as part of development and in the spirit of social justice."

This Report went on to stress the relevance of PHC to all countries from the most to the least developed, allowing for variations in national patterns and needs, but

"for developing countries in particular, it is a burning necessity"

and defined it as follows:

"Primary health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them,

through their full participation and at a cost that the community and country can afford. It forms an integral part of the country's health system of which it is the nucleus and of the overall social and economic development of the community".

This swing towards a broader perspective and a more holistic view of health stressed prevention rather than the accustomed curative approach. It advocated primary health care (PHC) not only as an ideology, but as a practical strategy essential to implementation of "Health for All". While recognising that each country might need to work out its own version of PHC, according to its individual needs and resources, the Declaration re-affirmed the responsibility of governments for the health of their people, and called on them to take urgent action on policy and practical plans to launch and sustain PHC as part of a comprehensive system of in-country health care. It called for international support:

- at government level
- between multilateral and bilateral agencies
- from and between UN agencies
- from and between NGOs

Its recommendations suggested ways of addressing problems associated with the failures of the 1950s and 1960s, some experienced during vertical campaigns as above, such as the difficulty of serving remote areas, and the need for training in management as well as in health activities.

Operationalising PHC

The broad concept of "PHC" is translated in the Alma Ata Declaration into a list of eight practical components forming a comprehensive public health approach to basic health care:

- **health education** (regarding prevailing health problems in the community, and methods of identifying/preventing/controlling them)
- **adequate food supply/nutrition** (promotion of food supply and proper nutrition)
- **safe water and basic sanitation**
- **mother and child health (including family planning)**
- **immunisation against the major infectious diseases** (thus incorporating into "PHC" a bio-medical technology of proven worth, such as EPI—Extended Programme of Immunisation—against six preventable diseases: TB, measles, polio, diphtheria, pertussis, tetanus)

- **prevention/control of endemic diseases** (according to in-country prevalence)
- **treatment of common diseases and injuries** (accepting the continuing need for curative care)
- **provision of essential drugs** (addressing efficacy, cost-effectiveness and availability)

This constellation of mostly preventive and health promotive activities (but not excluding curative and rehabilitative) is often referred to as **Comprehensive Primary Health Care (CPHC)**.

Implementation

The Alma Ata Declaration concluded with 22 recommendations as to how PHC, which it visualises as integral to the socio-economic development process, can be implemented. The recommendations range from integration into the national health system, based on national commitment and strategy, to practicalities like training manpower, using appropriate technology, logistical support such as transport, supplies and safe storage of vaccines. The Declaration also recommends more effective hospital utilisation, for PHC being a provision at basic level requires support from other levels of the country's health system equipped to deal with more complicated needs.

Thus the Declaration firmly places the responsibility for implementing PHC on governments. At the same time, in the second of its recommendations, emphasising community participation in health care, the Declaration indicates a move towards a more people-focussed philosophy, encouraging the growth of human potential and self-confidence—enabling factors ramifying into other activities, including those significant for development.¹ This focus in the Declaration modifies the presumption by health professionals (and others) of their exclusive status by virtue of specialised expertise and bio-medical knowledge, while it also clarifies that their skills and knowledge are still valued as part of PHC.

Reactions and rationalisations

Feasibility

Soon after the Alma Ata Conference in 1978, while some countries (e.g. Zimbabwe) attempted to operationalise PHC, doubts were expressed about the feasibility of PHC—or at

¹ For example, pressurising government departments to carry out such obligations as road repairs where these have been neglected, as Wardaga villagers were able to do (see Chapter 3)

least of CPHC. In 1979, Walsh and Warren lauded the goal of "Health for All by the Year 2000" as "*noble*" but pronounced it to be unrealistic and over-ambitious in scope. They proposed an alternative, "**Selective Primary Health Care**" (SPHC) on grounds of efficacy and cost-effectiveness in developing countries (Walsh and Warren 1979: Abstract). Their argument concentrated on medical-type interventions by health professionals, using low cost technology for delivering "selected" PHC components—measles and DPT vaccination, treatment for febrile malaria, ORT for children, tetanus toxoid, encouraging breast-feeding – possibly with some later additions. This service was to be delivered via mobile or fixed units; but their proposal did not address community participation. In contrast, the Alma Ata Declaration expects lay people to assume more responsibility, while indicating that their training will be the responsibility of professionals. The case for a particular version of SPHC was promoted vigorously by UNICEF (Taylor and Jolly 1988: 971-976) under the acronym GOBI (Growth Monitoring, ORT (Oral Rehydration Therapy), Breast-feeding, Immunisation) sometimes with the addition of FFF (Food supplements, Female education and Family planning)—the Child Survival and Development Revolution or CSDR. This model appears to depend on the use of qualified professionals rather than community participation.

UNICEF strenuously denied polarisation between SPHC and CPHC, arguing that

- *"SPHC is a package for priority but not for exclusive action"* (1988: 973)
- *"there is a chance that a global ethic of concern for children can be made a continuing development focus"* (1988: 974)

Taylor and Jolly also argue that SPHC is more realistic for developing countries, which often have economic problems. But even if children, as a selected group, may have been protected by a version of SPHC or GOBI in their earlier years, they may be exposed along with all other age groups to possible infection because of lack of safe water and sanitation, which are linked with poverty and disease. CPHC (as distinct from SPHC) is aimed at the *whole* community: "Health for *All*".

Finance

Cost was also included in the argument used by Robins and Freeman against CPHC as a realistic policy (cited by Wilson 1992: 46), in submitting that governments cannot afford the capital investment for major water and sanitation installations. This view assumes that provision depends on large-scale technical and engineering undertakings, presumably managed by highly qualified professionals—analogueous to the medicalisation of health care—whereas the Declaration recommends "*appropriate*" technology for health and associated

services on grounds of affordability and opportunity for participation, including maintenance, by the people themselves.

Counter-reactions

Opposing the case for SPHC, and describing it as a weakened version of PHC, Macdonald interprets it as a reaction from medical professionals to the radicalism of PHC (1998: 73). He writes that even where PHC policy and principles have been adopted, implementation has been in the hands of traditionally-trained health professionals, which he believes is likely to dilute impact and encourage medicalisation of the holistic and socio-developmental intent of Alma Ata.

By 1988, Walsh appears to have modified her original support for SPHC, commenting that

"the lack of impact of large-scale selective interventions is probably related to an inadequate recognition of the importance of community and political involvement and of the necessary social, cultural, financial management and administrative underpinning" (1988: 899)

This admits the relatively narrow focus of SPHC, and supports Macdonald's point that SPHC does not call for any significant shift of resources nor any transfer of power, such as is ultimately implied by community participation. Developing countries are often subject to internal political changes involving transfer of power, but these may take the form of power battles among the elite. Political instability and financial problems (including international debt obligations) of developing countries do not favour consistency or steady implementation and incrementation of policy and planning. Pakistan is a developing country which has experienced many changes of government since its creation in 1947, more than half of the time under military rule. Stapleton observes perhaps simplistically, but vividly

"One must realise that half the world is run by soldiers or policemen...they have to be convinced (of the importance of health care) because it is so often they who have to decide whether or not anything can be done " (1975: 292)

In fact the Declaration itself and its recommendations anticipate the financial implications of PHC (CPHC). The Declaration urges governments to adapt national budgets by increasing health allocations in preference to military expenditure, and to explore new ways of funding health care—not excluding contributions from the community. Additionally, and specifically within the field of health care provision, when 50-60% of health budgets in the developing world is spent on tertiary care (Carr-Hill 1994: 1196) the implication is that changes of a radical nature are required in political will and political decisions to effect new policies in favour of more equitable distribution of resources.

Governments, responsibilities and practicalities

As mentioned, the Declaration firmly places the responsibility on governments for implementing PHC. 150 countries (including Pakistan) accepted the Alma Ata Declaration, and about 100 of these supported it with legislative back-up (Taylor and Jolly 1988: 972). Country examples of governmental implementation of PHC cited in the literature as effective are

- Cuba—a socialist system and a population of about nine million
- China—also a socialist system but with a vastly greater population (over one billion) and a history of grassroots involvement in health care as part of a large-scale transformation of social organisation (Crow 1992: 29).

A commitment to equitable re-distribution of resources based on socialist ideals has been influential in these widely different cultures, noted by Wilson (1992: 53)

- Sri Lanka's and Kerala's improvements in the health care field are linked with high levels of literacy (Drèze and Sen 1989, cited by Wuyts (1992: 26-27)
- Malaysia (pop. 22.3 million) has also achieved outstandingly high levels of life expectancy.

“Evidence from these high performers shows that governments emphasised system-building and spent more on health and education; they invested in comprehensive and widespread maternal and child health services at the primary level, with good referral systems. They also made substantial efforts outside the health sector especially by investing in clean water and sanitation and often providing a nutritional floor below which the vulnerable were not allowed to fall” (Rowson 2001: 6).

In 1975, as mentioned above, Newell had set out how quite simple health techniques could effect improvements in the health of ordinary people. He also considered that the success of any new system depended on

“linking it with an indigenous system or attempting to play a role having some of the same social qualities that the existing systems had”

That this kind of insight and vision underlying the principles of PHC has not been fully understood, and also has some limitations, is evident from literature on some less effective attempts to introduce PHC, in countries of more than one continent. To do justice to each individual national effort and its critics, a series of country-based studies would be required; this is not the place to go into such detail. A summary of some common and recurring problems mentioned by writers from several countries will introduce the more topic-relevant case of Pakistan.

Problems

There are several groups of problems which appear in accounts of national attempts to introduce and sustain PHC. Sometimes in the first flush of enthusiasm after independence, new governments of former colonies did attain a degree of effectiveness demonstrable in health indicators by introducing appropriate training for staff, increasing numbers of clinics and realistic siting of facilities to enable access. But **economic factors** outwith government control can intrude, such as rising inflation, reduced income levels, and persisting external debt obligations because of aid from developed countries. All have implications for health care funding and for poverty, with consequent malnutrition and reduced levels of health. Within some former colonies, the new political leadership took over the privileges of the former elite—in Pakistan, these are known as the “brown sahibs”—including their received expectations of urban hospital-biased techno-medicine, thus perpetuating inequalities. In such circumstances, PHC could be at risk of being seen as a second-class service for the poor.

In these as in other (non-colonial) developing countries the literature identifies negative **organisational factors** believed to have affected implementation of PHC :

- over-centralisation
- increased bureaucratisation
- piecemeal approach
- inadequate training and supervision
- inappropriate re-deployment of staff
- insufficient attention to locally varying needs e.g. standardised packs of supplies

Socio-cultural factors such as restrictions on the mobility of women (staff as well as patients) have contributed to the difficulties of serving remote areas. In spite of improved public-health oriented curricula for doctors in training, the expectations of the extended family, who may have supported them during their training, can influence them towards more lucrative private practice, most likely urban-based. Accustomed health practices might be harmful and difficult to discourage, and there might be religious objections to modern methods of contraception. Involving ordinary people at community level in planning and implementing PHC did not happen, for two reasons. Either health professionals with a curative-biased training continued to dominate new systems, or the more broadly-based ideas fundamental to PHC were not fully understood. If there was no evidence (or experience) of sustained improvement, people could become disillusioned, disappointed and lose faith.

Some instances of these obstacles exist in Pakistan—economic, political, organisational and socio-cultural. Examples will emerge in the following sections on Pakistan and its health and health care problems.

Pakistan: background

Pakistan as a developing country faces the familiar problems of poverty, low levels of education—especially for women—poor health indicators, increasing population, and problems of serving rural or remote districts, where transport and communications are inadequate. As a political entity separate from India Pakistan has existed only since 1947, the date of partition, when it comprised the two “wings” of East and West Pakistan.

Present-day Pakistan was further re-defined after the disruption resolved by the secession of East Pakistan to become Bangladesh in 1971. This was not the only destabilising factor in Pakistan’s life as a new nation. There were others.

Firstly, the death of Mohammed Ali Jinnah (“Father of the Nation”) within a few months of partition led to political instability, including recurring periods of military government. India by contrast had 14 years of Jawarharlal Nehru as Prime Minister in the critical initial phase of a new identity. Then there were the practicalities of re-settling large numbers of Muslims from India who chose to move into Pakistan at the time of partition. Relations with India deteriorated, culminating in the Indo-Pak war of 1965. Mutual suspicion has persisted, not helped by both countries acquiring nuclear capability in the late 1990s. Kashmir remained a focus for disputes and military activity.² In the mid/late 1970s, what started as a fairly controllable problem—the migration of refugees from Afghanistan—increased dramatically in 1979/80 and later years, as recounted in Chapter 3. Finally, Pakistan shared the aid/debt problems of developing countries, with the addition in its case of the Pressler Amendment of 1992, prohibiting the extension of US assistance to countries alleged at the time to be developing a nuclear capability.

These political, military, and practical pre-occupations resulted in health policies having a lower priority for GOP. This affected financial allocations to the social sector, although at the time of the secession West Pakistan (present-day Pakistan) had better economic prospects than the East “wing”. Its agriculture had improved, and it was more industrialised. Present-day Pakistan has been the object of external (and sometimes internal) criticism because its military governments are considered non-democratic; but its most recent

² But in February 2004, India and Pakistan re-started talks on Kashmir.

"democratic" governments (Benazir Bhutto, Nawaz Sharif) have been characterised by charges of corruption. They appear more like the power struggles among the elite suggested by Macdonald (above) than debates between ideological opponents, Benazir belonging to the landlord class while Nawaz is an industrialist. At grassroots level, expatriates long resident in Pakistan, as well as local people, in telephone conversations with me in October 1999 after the coup by General Musharraf, welcomed the military government as stabilising, and likely to reduce corruption (MMP Journal).

The tensions endure between democracy and some other system providing stability and order in Pakistan. Ex-President Leghari of Pakistan, expressing doubts about the constitutionality or legality of possible army-influenced arrangements after the promised elections, admitted the dilemma—*"but we do need stability and order"* (Bennett-Jones 2002). Just before the general elections of October 2002, President Musharraf arranged the continuation of his presidential role for another five years.

Pakistan: health and health care

The recognition of the magnitude of health problems in India/Pakistan and attempts to effect improvements has long historical roots. Colonial neglect, and especially neglect of public health is often cited as the reason for the state of health of the population of India (and of former colonies of other western nations) as it is in Pakistan's Draft National Health Policy document of 1989 which covers the years 1989-99. Such schemes as existed in colonial times tended to be curative-oriented and likely to benefit the expatriate residents. They might be set up for the armed forces (still the case in Pakistan), or by industrial businesses with an interest in maintaining a healthy workforce as in the tea and mining industries in India (Jeffery 1988: 36) or charitable or missionary foundations, like Chogoria in Kenya (DeBoer and McNeil 1989: 1007)³ Within what is now Pakistan, there was in colonial times no generally available comprehensive system. Yet even before the 1947 partition, while the colonial power still ruled, the Bhole Commission Report of 1945, referred to in the 1989 Policy document mentioned above, addressed the state of the nation's health. Although its hopes were overtaken by events, Bhole identified the following needs for improvement (referring then to the whole of colonial India) to be implemented by 1986:

- emphasis should be on health, not sickness
- healthy environment

³ There are about 70 missionary health-oriented initiatives in Pakistan, 25 hospitals and the rest clinics or programmes. My informant, a long-term expatriate resident in Pakistan, has asked me not to refer to any of these by name because of current anxieties about security (personal communication 25.05.04).

- affordable, accessible health care
- small units of administration
- adequate financing
- health education

These elements indicate an early interest in a less curative-oriented approach, in common with ideas ultimately embodied in the PHC strategy. The 1989 Draft Policy document admits that in the period after partition 1947-1970 little intellectual activity went into health planning; probable distractions have been set out above. However, in 1959 i.e. before Bangladesh seceded, the Basic Democracies Order of the Government of Pakistan (GOP) had made it incumbent on Union Councils (the lowest local authority unit in Pakistan) to assume responsibility for community and personal health and to undertake basic health functions. Also in the 1950s the GOP (i.e. covering both East and West "wings") addressed the promotion of the country's development (including health) by embarking on a series of Five Year Plans. And in the voluntary sector, in the early 1950s, a number of concerned individuals came together to form the NGO "Family Planning Association of Pakistan" (FPAP), another instance of growing awareness of the importance of the health of the majority—the poor.

In 1969 the Public Health Association of Pakistan's published its report, *"The System of Local Health Services in Rural Pakistan"* at the request of the Planning Commission of Pakistan. The highest governmental and professional levels thus demonstrated that the needs of rural people were being considered seriously. This paper is of special interest to this case study, which is concerned with rural people. At the time, it was reckoned that 86.9% of the two "wings" of Pakistan lived in villages, the rest in cities; in spite of some urban drift in today's Pakistan, 60-70% of the population lives in the villages.

Pakistan: rural health and health care

The foreword to the Public Health Association's 1969 paper mentioned above records GOP Health Department's concern about the health of the rural population. It lists as the most important health problems in rural areas:

- lack of vital statistics; lack of understanding of their importance
- poor environmental sanitation
- high infant and maternal mortality rates

- high fertility and rapid population growth
- malnutrition
- high prevalence of preventable common diseases
- intestinal infections
- lack of school health services
- inadequate facilities for private/public medical care programmes
- apathetic attitude of people towards health

The problems were not and are not exclusive to Pakistan; the literature cites them as typical of developing countries—including the deficiencies of data collection. The 1969 paper quotes the UN Yearbook of 1965 as listing 37 nations in Asia, of which seven were adjudged to have reliable vital data (not Pakistan). The paper also stresses the importance of health needs of women and children, and problems of training and locating female staff where they are needed. Some improvements in health are noted, ranging from slow but sure fall in the death rate since the early decades of the 20th century, and the expected eradication of smallpox—in 1969 still endemic in Pakistan. The paper was optimistic about the malaria eradication programme—as outlined early in this chapter eventually modified to one of control.

As a pronouncement by a public health institution, this 1969 paper is explicit about reasons for unsatisfactory health care in rural areas:

- urban/rural discrepancy e.g. of the 852 MCH Centres in existence, most were in urban areas; total number required: 12,000
- absence of dynamic and purposeful leadership
- Health Departments appear not interested in helping people to become responsible for their own health
- local authorities uncertain of their health role (laid upon them by the Basic Democracies Order 1959, above)
- lack of basic health facilities—70% of Union Councils without even a basic dispensary for elementary medical care
- lack of guidelines and manuals
- lack of goal-orientation e.g. towards reduction in IMR
- no job satisfaction for staff—frustration and apathy
- local financial contributions are given unwillingly if at all because of dissatisfaction with service

Declaring that Pakistan's health problems are simple and basic, but of colossal proportions, the paper proposes action, including even a "crash" programme. The proposals swing towards community-based preventive health care, away from individualistic curative practice:

- integrated rural health service, basic and unsophisticated
- integration of malaria/family planning with rural health programme
- stimulation of co-operation and interest of "consumers"
- undergraduate courses to include public health
- leadership by doctors qualified in public health/rural sociology
- public health doctors to be accorded high status (as specialists)
- delegation to the periphery of authority as well as responsibility
- curative care retained, as "sugar-coated pill" of preventive medicine
- "auxiliary personnel" to be trained in specifically limited functions
- health education in the school curriculum—for teachers too—on clean water, refuse disposal, use of latrines

Many of these are echoed in the Report of the Health Study Group which met in Lahore in 1970 and quoted above, advocating a specific Rural Health Programme. This Report (co-authored by the writer of the Rural Health Services paper of 1969) takes a more strategic approach addressing health needs across the whole population, and is not restricted to rural provision. It suggests a balance between curative and preventive work, recommending early emphasis on preventive health, targeting vulnerable groups. It wants improved financial allocation, a fuller role for the private sector, and planning for a second longer-term stage of more general development. It warns of the danger of population explosion, expected to double in less than 25 years from 1970, and recommends the inclusion of family planning (initiated in the 1950s) into the Rural Health Programme.

These documents are evidence that within Pakistan a body of knowledgeable strategic thinkers existed some years before Alma Ata declared for PHC in 1978. They understood the need for expansion and change in emphasis in health care delivery. They wanted action, especially on behalf of the rural population.

Bridging policy and practice?

Page 26 of this 1970 Report on rural health refers to GOP's First Five Year Plan of the early 1950s; it was emphatic that first priority would be given to preventive measures in order to raise standards of health throughout the country at relatively low cost. But, says the Report

"official practice has consistently been the opposite of declared official policy. We have yet to create the basic framework of a preventive health service"

Without going into detail about succeeding Five Year Plans, variations of this statement, offering possible explanations of dilatoriness in implementing their health content, recur in later reports and papers on health care in Pakistan throughout the 1970s, the 1980s and into the 1990s. Examples are:

1973: "policies followed are at variance to those expressed in public statements and plans" (Jeffery 1973: unpublished)

1987: "public policy regarding health (mainly a government responsibility) has always diverged on paper and in reality because powerful interest groups do not see it as necessary or desirable for health systems to undergo a radical change" (Sathar 1987: 1)

1987: "The fundamental weakness is the failure to analyse (in the face of constraints) alternative ways of achieving established goals ranked in order of priority" (Chakrabarti et al. 1987: 77)

1988: "Pakistan has not articulated a coherent health policy or shifted resources towards sectors identified as priorities such as rural preventive health campaigns using paramedical personnel". (Jeffery 1988: 296, comparing India's relative effectiveness as a health care provider)

1993: "In general, health system development suffers from contradictions. Stated goals as presented in five-year plans are inconsistent with the approach taken to achieve these goals. In effect, good intentions are thwarted by practices which undermine the establishment of a sustainable and effective health system. In the course of decision-making for health, planning becomes separated from actual implementation of health activities which has led to inefficiencies and imbalances in resource allocation" (LaFond and White 1994: iv)⁴

Comments are not all negative. In 1987 Sathar (p.2) recognised Pakistan's achievements in wiping out smallpox, cholera and famines—though malnutrition persisted, if not starvation. In the same year, Chakrabarti et al. in the Pakistan Health and Population Sector Review (p 6) note the mid-70s conscious shift in policy to preventive care and the development of PHC facilities; in 1985 a five-point programme called for a Basic Health Unit (BHU) or Rural

⁴ All these comments refer exclusively to GOP's health system. From 1980 onwards, as explained in Chapter 3, Pakistan had to cope with the large influx of refugees from Afghanistan, mostly into NWFP. From its inception, the new UNHCR/GOP Afghan Refugee Health Programme operated independently from the GOP service for its own nationals, except for the informal use acknowledged by the Programme Officer (Health) of UNHCR, interviewed in Islamabad in 2001.

Health Centre (RHC) in every Union Council. This provision was expanded in the 1980s, and in the 1990s other measures were introduced as below.

Improvements and comments: the 1990s

The Prime Minister's Scheme

During Benazir Bhutto's last term of office in the mid-1990s, she introduced the "Prime Minister's Scheme" for training Female Health Workers (FHWs) intended to work at grassroots level delivering health education and stressing preventive measures to improve health. Thousands attended centrally organised training courses. The training was appropriate and of a good standard, according to a senior doctor at Trust for Voluntary Organisations (TVO) in Islamabad, but he said that the problem of deploying female staff to remote areas remained unsolved. My interviews at GOP BHUs produced no evidence of built-in arrangements for integration of the FHW Scheme with the existing BHU system, though the Medical Officer (MO) of one GOP BHU team in Swabi District had set up regular meetings on his own initiative with the FHWs in the area. This MO criticised official supervision arrangements for these workers as ineffective—and the scheme itself as "*vertical*"—criticisms echoed by senior staff at FPHC.

The Participatory Development Programme

In 1995, as part of a drive to tackle serious problems of basic welfare, the Government of Pakistan introduced its Social Action Project, including the "Participatory Development Programme" (SAP/PDP), Phase 1 of which ran 1996-97. In its four targeted areas of Education, Water/Sanitation, Health, and Family Planning, it appeared a sincere attempt to tackle major problems, but the categorical approach of SAP/PDP 1 does not accord with the idea of integration of the eight fundamental components of PHC (even Family Planning and Health were separate from each other). While it did demonstrate a shift in GOP's attitude to NGOs and a positive view of community participation, neither NGOs nor the funds (from the World Bank and backed by a Multi-Donor Support Group in Islamabad) can provide a universal service, which Alma Ata regards as a governmental responsibility.

World Bank and Multi-Donor Support Group representatives announced at a meeting at the University of Peshawar in June 1998, which I attended, that SAP/PDP 1 though not without problems of reporting and delay in forwarding cash instalments to NGOs, had demonstrated enough positives to allow SAP/PDP 2 to start as a follow-on from Phase 1. Applications for Phase 2 were encouraged, but by year 2000 no awards had been announced. In other words,

Phase 2 did not follow-on, a failure which reportedly created problems of service-delivery—even survival—for smaller NGOs.

Devolution: local government and health care

In the Introduction to the 1999 Annual Review of Social Development in Pakistan (SPDC), Dr. Akhtar Hameed Khan complained of the deteriorating quality over the years of governments in Pakistan: effective and accountable local government units had been replaced by weak central government, stressing the importance for basic services of strong local government units and local activity. Dr. Akhtar also drew attention to the disregard by the rulers of Pakistan of the poorer sections of society. Charitable intentions regarding the poor are not enough: Zaidi in arguing for structural change in Pakistan, states that:

"in spite of religious obligations to give generously to charity, the elite in a country who to a great extent determine the role of the state and the government are only willing to give a certain amount of charity, and nothing more. They will clearly never give the poor so much that their own (relative and absolute) position is threatened." (1988: 119)

The SPDC Review explains that Pakistan, while it does have an external debt burden (50% of its GNP) does not have a problem on the scale of e.g. Mozambique (444% of its GNP) or of Peru. The implication is that Pakistan should have more financial leeway to improve services. Since the time of the publication of this SPDC Review, there has been some re-organisation of local government and local elections, with a new kind of official, the Nizam, who has a duty to be involved with local services. But one Deputy District Health Officer—the title has been changed to Executive District Officer (Health)—said at interview in April 2002 that he was now confused about possible multiple accountability: to his immediate superior, to the Nizam, to the Minister —*"they all have different ideas"*.

Increase in facilities

According to Malik and Nazli (1999: 364-5) by 1995 there had been a considerable increase in the numbers of facilities: 4925 BHUs, 498 RHCs, and increases in numbers of trained staff, doctors of both sexes, LHVs and midwives. But no plans were in place for phasing out or integrating existing schemes into basic health care, so that vertical programmes and dispensaries and MCH Centres continued (as I found during fieldwork), with a negative effect on optimum deployment of staff. Malik and Nazli further declared:

"The high population growth rate offsets the expansion of health services and therefore the overall coverage remains low" (1991: 365).

"Perpetual inequity"

Attempts to address population growth rate will be explored in a later chapter, but Malik and Nazli's statement confirms that failure to provide effective basic health care in Pakistan is chronic. In 1993 LaFond and White's study *"Sustainability in the Health Sector"* dealing specifically with NWFP where the population is predominantly rural, noted the internal resource allocation patterns as continuing to favour urban-based hospital services, curative bias in health training and over-centralisation of planning and management. All these criticisms reiterate those of writers in earlier decades. LaFond and White apply the phrase *"perpetual inequity"* in connection with resource allocations. It could be applied more generally to the functioning of the health service in rural NWFP, according to the negative perceptions of GOP BHU patients interviewed during their study:

- inconvenient siting of health facilities
- lack of consultation
- lack of equipment and supplies (less so for EPI)
- lack of transport for patients or staff (for outreach work)
- staff absenteeism
- no home visiting

During my fieldwork I recorded much the same criticisms from patients and staff of GOP BHUs, one in each of three Districts of NWFP in 1997, 1998, 2001 and 2002; the last was nearly ten years after LaFond and White's study. My many informal conversations recorded in field notes, as well as formal interviews, with individual members of the public and health workers at various levels also support the persisting negative perception of the GOP basic service in NWFP. In 1997, 1998, 2001 and 2002 according to fieldwork evidence it appeared

- curative rather than PHC/public health focussed
- limited in provision (e.g. polio immunisation via vertical campaign-type programmes delivered by visiting Health Department teams)
- subject to shortage of drugs, medicines, even stationery
- volunteer health workers not used
- variable knowledge and understanding of PHC
- insufficient delegation of authority
- frequent staff changes at BHU and District level, and/or delay in replacements
- prolonged delay in repairs to buildings/equipment/water supplies to BHUs
- lack of supportive supervision for those in the front line
- low staff and patient morale

All the BHUs and District Offices which I visited were easily accessible from District and Provincial Health premises in Mardan, Swabi, Charsadda and Peshawar between one and three hours' drive along good roads, so distance is not a valid reason for delays and supply difficulties for these locations. Apart from the criticisms cited above, there appears to be a pervasive attitudinal lack: when JSP and MMP arrived in Pakistan as VSO volunteers in 1991, the Field Director of VSO, a Pakistani brought up and educated in the UK, said to us

"You must realise that there is no concept of service-delivery here" (MMP Journal)

an opinion echoed ten years later in December 2001 by Dr. Zamani, now employed in USA, when I interviewed him:

"People in developing countries do not seem to take their jobs seriously"

His comment is based on his work experience in health settings in Afghanistan, Pakistan, Bangladesh, the UK, Vienna and California.

GOP and health care in 2000/01/02:

NWFP Health Department

The Provincial Health Department as part of the government structure is staffed by civil servants as well as by senior health professionals, part of a long-established bureaucratic system inherited from colonial times. The civil service is sometimes credited with providing a degree of stability during the periods of turbulence in Pakistan's history, but like the army, another powerful institution, it is hierarchical and not a representative body.

The Provincial Health Minister, Dr. Shaheen Sardar Ali—a Professor of Law and the first female Minister in NWFP—appointed following General Musharraf's coup of October 1999 was very aware of the challenge posed by the poor reputation of the provincial health service and its failure to deliver. She had verified it for herself on numerous informal visits to BHUs, when she had many conversations with patients (interview in Peshawar in 2001). She was frank about shortcomings and keen to try to promote changes especially in basic health care and family planning; but she pointed out that she was dependent on her Departmental staff. She had achieved the construction of two rubbish disposal incinerators, and set up discussions with Islamic scholars with a view to encouraging more positive attitudes to family planning. She believed it had become entangled with religious issues, and that it stood a better chance if health aspects were emphasised. At time of interview she had only recently returned from the UK, having initiated discussions with DfID and the Nuffield

Institute on forward planning. At the end of 2001, she was no longer in post, but her successor is also a woman, a former professor of paediatrics, reported to have developed an interest in preventive work (MMP Journal 2001). Both these Ministers have visited FPHC.

In Pakistan, in year 2000, many of the obstacles to providing basic health care were still evident, in spite of good intentions, real effort and some achievements by individuals at senior and local levels. The question arises as to whether PHC is a realistic goal for Pakistan.

PHC in year 2000: a global view

Laurence Malcolm, in a 1994 editorial for *Social Science and Medicine*, said

"Despite widely held expectations of what this new approach might achieve, progress towards health systems based upon PHC with its emphasis on social justice, a broad concept of health, inter-sectoral integration and participation by communities in developing comprehensive, equitable and holistic treatment and preventive services has been slow".

Six years later, in year 2000, Gro Harlem Brundtland, then Director of WHO, in her fourth of the Reith Lectures re-affirmed her belief in PHC. Improvement in the health of the poor is possible, she said, if there is a higher percentage of national investment, increased GDP, enhanced international commitment, together with internal political will at the highest level. She conceded failure to secure even a basic level of health for three million of the world's poorest people, but argued strenuously for better health for poor people as essential for sustainable development, because improved health should lead to better social and economic functioning. What she criticised was not the PHC strategy itself, but attempts at PHC which are poorly focussed, poor quality and inadequately financed. Her criticisms are applicable to governmental efforts at basic health care in Pakistan.

Conclusion

In the second half of the twentieth century, interest in public health and the emerging concept of PHC created international concern, particularly for the variable but generally low standards of health and health care in developing nations. Awareness of the discrepancies between and within nations drew together many interested parties under the leadership of WHO, supported by UNICEF. This culminated in the 1978 Declaration of Alma Ata, which expounded PHC as a strategy applicable to all countries, and for developing countries "*a burning necessity*". The Declaration addressed practicalities of implementation, stressing particularly the need to involve ordinary people—community participation—as important

contributors to improvements in health, using simple inexpensive procedures. The Declaration did not reject modern techniques where they were of proven effectiveness, and recognised the expertise of health professionals especially as trainers. It laid the responsibility for implementation of PHC firmly on governments.

The perceived impracticality of PHC led to modified versions being promoted in the form of Selective Primary Health Care (SPHC). This can be criticised as limited, short-term and biased towards the use of professionals. Literature on Comprehensive PHC shows that governmental implementation, while there are some notable successes, is patchy world-wide and not always sustainable even when it gets off to a good start. Possible reasons for failure may be political, economic and cultural. Need, especially of poor people, remains great.

From the earliest years of its existence as a nation, Pakistan formally recognised its own great need in the field of health and health care. Indigenous senior health personnel and academics as well as external consultants have produced critiques urging a move towards preventive medicine and universal basic health provision along the lines of PHC. National legislation has repeatedly supported this since 1947, along with international aid, emphasising particularly the needs of the rural poor, admitted to be more disadvantaged than city dwellers. But practice has not matched expectations and plans, even when backed by apparently well-organised schemes. Although recurring major political and economic obstacles do exist, in the year 2000 there was evidence at executive and field level of failure to integrate programmes, persisting lack of commitment, poor staff motivation and standards of practice, inadequacies of equipment and supplies, and patient dissatisfaction. Increases in numbers of facilities and of trained staff have made some contribution to improvements in health indicators, but progress has been largely offset by persisting rapid population growth. GOP's chronic failure to match implementation and practice with policy has been well documented.

The Alma Ata Declaration encourages involvement of NGOs in the health field. GOP in setting up Phase I of SAP/PDP appeared to support this by demonstrating its new interest in NGOs as partners in health care, but by year 2000, Phase II had failed to start. The field remained open to alternative health care agencies, including NGOs.

It is interesting that two NGOs frequently quoted as examples of successful implementation of basic health care along PHC lines are located in countries of the Indian sub-continent, namely Bangladesh and India: the Comilla Project in Bangladesh (Macdonald 1998:110) and the Jamkhed Project at Marahashta in India (Arole and Arole 1975, cited by Newell 1975, Djukanovic and Mach 1975, also Macdonald 1998:106). These two developing countries

share historical and socio-cultural associations with Pakistan, and have similar health problems. Their success shows that the barriers to PHC in South Asia can be overcome by NGOs.

The next chapter will consider the roles and activities of NGOs as health care providers in developing countries generally, and particularly NGOs in Pakistan.

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CHAPTER 5

HEALTH-ORIENTED NGOS IN PAKISTAN

The question arises as to how and why NGOs have been successful in implementing PHC. This chapter defines the broad organisational category "NGO", and explores its attributes, with special attention to health-oriented NGOs. The chapter sets the NGO scene in Pakistan, including health-oriented NGOs. It locates FPHC (and its predecessor ARC/PHC) within the NGO context in Pakistan, identifying some characteristics FPHC shared with other health-oriented NGOs, and also some characteristics belonging to it alone.

Because FPHC has two target populations, refugees and non-refugees, the chapter comments on the discrete nature of the official basic health care services provided for these two populations by the different national/international responsible agencies. It also draws attention to the separate categories of NGOs working with the Pakistani population and NGOs working in refugee health care. The chapter demonstrates that NGOs providing basic health care to Afghans have shrivelled in number from a maximum in the early 1990s, and that FPHC is unusual in its continued existence from 1980 until 2000 and beyond.

I will argue that basic health provision for Afghan refugees and the part played by NGOs in that has been insufficiently researched as a potential reservoir for lessons to be learned about primary health care, and that these lessons could be useful to GOP and more broadly.

What are NGOs?

Non-governmental organisations or NGOs are distinct from both government and private/for profit agencies, making up what is sometimes called the "Third Sector" (Jareg and Kaseje 1998: 820). In the UK, there exists a large and dynamic voluntary sector, suggesting that within a democratic society there is freedom to voice many concerns, to act on them and to draw the attention of government to them, sometimes with a view to influencing policy and legislation. The National Council for Voluntary Organisations (England and Wales) publishes annually the Voluntary Agencies Directory, which in 2002 listed 35 categories of voluntary bodies by beneficiaries, fields of work and functions. While voluntary bodies are not confined to organisations concerned with humanitarian issues and social justice, many *are* concerned with such issues, have a long history and are active beyond the frontiers of

their country of origin. Some began and continue to be known as "charities", but the categories "charitable", "voluntary", "non-governmental", and "private" can sometimes overlap; distinctions can become fudged, in some cases because of historical roots.

Defining NGOs—and defining health-oriented NGOs

Green and Matthias restrict their use of the term NGO thus:

"We are using the term NGO to refer to formal organisations which have corporate objectives concerned with humanitarian aims concerning groups outside the organisation, which are non-profit-making and are outside the control of government". (1997: 32)

In their preface to *"Non-governmental Organisations and Health in Developing Countries"* Green and Matthias remark on the growing body of literature on NGOs, linked with the general increase in their number. This increase occurred both within industrialised countries and in developing countries, and in the international field. The wider socially conscious public perceptions after World War II and changes in governmental responsibilities in the associated post-colonial era influenced the increase.

However Green and Matthias point out that much of this literature is concerned with NGOs working in the more general community development fields, whereas less has been written about NGOs working in health. For example, Korten's comprehensive study *"Getting to the 21st Century"* (1990) is largely concerned with aspects of community development and barely mentions health or health-oriented NGOs. According to Green and Matthias, the surge of interest in specifically health-oriented NGOs is comparatively recent. Introducing their study, they work towards a more precise definition, and settle for the following:

*"We will be using the term to refer to organisations that are formally constituted, with the primary non-profit-seeking objective of improving the welfare of a group or community wider than the direct membership of the organisations and with a decision-making authority independent of government. They may achieve their aims in a variety of ways ranging from direct service-provision through to the provision of support to other NGOs. **Health NGOs are a sub-set of such organisations with a specific objective of health improvement.**" (1997: 32, emphasis mine).*

NGOs and the Declaration of Alma Ata

Having remarked on the scarcity of literature on health-oriented NGOs, Green and Matthias make a second point that not much has been written about the implied relationship in developing countries between NGOs and the state as agency with overall responsibility for

health and health care. Both definitions above mention the status of NGOs vis-à-vis government.

Around 1980, interest in health in developing countries focussed on the public sector. This arose from the assumption in the Declaration of Alma Ata that governments would be responsible for implementing Primary Health Care. In stressing the need for co-operation of various kinds between governments and international agencies in the interests of better health care, the Declaration also includes NGOs as potential collaborators (1978: 6). It does not particularise how collaboration might come about nor does it identify any advantages or disadvantages, but the reference indicates that by 1978 NGOs had attained resource status in the eyes of WHO and UNICEF, both instrumental in composing the Declaration. A later document, the Report of the World Health Assembly in Riga (1988) notes that by that time ideas about "Health for All" had become pervasive in NGO circles. This Report stressed the great potential of NGOs in the health field, in spite of variable performance, and recommends that ways be found to encourage their participation (1988: 36, 38, 67).

Health care in practice

The Alma Ata ideology of PHC and the stress on governments as the agents with overall responsibility for provision accords well with Green and Matthias' interpretation of health and health care as a human right. As such it should be universally available, as explained in Chapter 4. In practice, however, as Green and Matthias point out, in many societies across the globe, health care is available from a mixture of sources:

- from the state in the form of a national health service funded by government funds and various insurance methods
- from profit-motivated private practitioners or institutions for direct payment
- from not-for-profit agencies such as voluntary hospitals or specialist agencies including NGOs

This statement does not assume that where this combination exists it is effective in providing for the health needs of whole populations, nor that there is any policy of co-operation or collaboration between them. As far as Pakistan is concerned, the above three sources of health care are present—state, private for profit, and NGO-based. Chapter 4 described the Pakistan **government's** failure to establish a universal basic health service, though there is evidence (as explained in Chapter 6) that it does function to a limited extent. Special governmental arrangements exist in Pakistan for certain categories of employees (see chapter

4)¹. In common with other developing countries, in present-day Pakistan the **private** health care sector is subject to the usual problems of high cost to patients, irregular distribution and variable accessibility, especially in rural and remote areas. Some health care in what is now Pakistan was available in colonial times from **missionary/charitable** sources², but such provision inclined towards a centralised/institutional model, often with a training component e.g. the Lady Reading Hospital³ in Peshawar—or perhaps specialised like the eye hospital in Baluchistan.

The assumption that governments should be responsible for effective universal health care provision does not sit well with criticisms of governments of developing countries (including Pakistan) as corrupt, crippled by bureaucracy, and allocating funds inappropriately e.g. financing defence in preference to public services, referred to in Chapter 4. Corruption may pervade public services at operational levels too, as well as inefficiency and lack of accountability. Green and Matthias also criticise governments on the grounds that

"policy-making in many countries is characterised by introspective and defensive attitudes which fail to recognise the potential importance of alternative views" (1997: xii)

on ways of facilitating health care. This is not a simple matter, for even if a government is well-disposed towards health NGOs, the field is wide, reflecting the huge range of health concerns, whether curative or preventive. Reviewing possible alternatives requires comprehensive information of what exists, as suggested by Korten (1990: 121). In the absence of any centralised system of information, co-ordination or monitoring, as outlined below, it is difficult to see how GOP at either a Federal or Provincial level can make a comprehensive assessment which would enable them to consider the feasibility of "alternative views".

Analysing NGOs and their development

Green and Matthias start by distinguishing between two broad groups of NGOs active in developing countries, while drawing attention to the diversity and complexity within each:

- **INGOs** (International NGOs) *"operate mainly, but not necessarily exclusively outside their country of origin...most of the better-known ones are products of the twentieth century, and very few had a role in the initial development of*

¹ The Pakistan government provides medical care to service (and ex-service) men and their families and allows reduced fees at certain schools for children of serving and retired military personnel.

² See also Chapter 4, footnote no.3

³ Lady Reading was the wife of the Viceroy of India 1921-26.

modern health care in the countries in which they now operate. Many however were involved in the introduction of PHC policies" (1997: 62)

- **CYNGOs** (Country NGOs) *"alternately referred to as indigenous or national NGOs. We define CYNGOs as NGOs which are totally operational, managed and accountable within their own countries" (1997: 74)*

Oxfam and Save the Children are two frequently quoted INGOs working in many developing countries. Oxfam (originally the Oxford Committee for Famine Relief) is an example of a western NGO created as a response in the post-war era to disasters in the non-industrialised countries. Oxfam's "Freedom from Hunger" campaign of the 1960s exemplified the later strategic move from relief to development work. Understanding grew that relief measures were not enough, and in the long run could even have a negative effect, creating dependency on the part of recipients (Korten 1990: 141). Save the Children expanded its work overseas. Started as a children's rights organisation in the 1920s, in the 1980s it added health to its remit, health being regarded as one of those rights (SCF-UK 2003: 1). Both of these NGOs as dynamic organisations have changed because of their openness to the shifts internationally in development thinking and health policy. Médecins sans Frontières (MSF) is another NGO which has moved from entering disaster situations geared to undertake immediate life-saving surgical and resuscitation techniques towards interventions with longer-term effects linked to development (MSF 1997: 243-248).

Some INGOs have established reputations as critical analysts of international policy developments based on their own on-the-ground experience (Green and Matthias (1997: 18). Godfrey notes that the activities and interests of many NGOs have provided opportunities for institutional growth i.e. not in the field only, but in their head offices. Oxfam for example created a special unit for health work, and SCF recruited health professionals based at its headquarters in London (Godfrey 1993: 263).

Within Pakistan INGOS are visible both as donors and implementers of projects. For example, Save the Children (SCF UK) in NWFP during the mid-1990s was a partner as a donor with the World Bank and the Provincial Health Department in the Family Health Project based in Peshawar. It was also an on-the-ground provider of health care in some refugee camps in NWFP, and a pioneer of CHW training, as explained in Chapter 3. INGOs can be criticised on several grounds. Key (1990: 2) remarks on lack of understanding on the part of INGOs of the priorities, performance and relationships with other forces in the development process, though this has not prevented donors from providing money and technical advice. INGOs can also be deficient in knowledge of in-country social organisation, cultural patterns—which may vary within a country—and health practices, leading to premature attempts at change. Pakistan is not a homogenous country: in NWFP

the predominant and distinctive Pathan culture imposes a code of behaviour stricter than elsewhere in Pakistan. Even where an NGO is sensitive to cultural issues, problems may persist. Chapter 3 showed that ARC, as the INGO it was in the beginning, did recognise that cultural limitations affected the delivery of health care, particularly in its early days. Having a high proportion of Afghan staff probably helped to reduce problems; even so it was important to proceed slowly and to win the trust and confidence of camp residents, essential if a new style of health care was to be introduced and accepted. Nevertheless the restrictions on women continued to affect female staff as well as female patients for many years, as evidenced more than once in this study.

Misunderstandings related to local customs and health practices are less likely to beset CYNGOs. By the time ARC's health project had effected the transition to its new identity as a CYNGO in 1995, its settled location and relationship with local non-refugee people meant that while education of the new target group was a continuing need, some problems were reduced in intensity. It was more acceptable for female staff to travel, and for women patients to attend Health Centres. As explained in earlier chapters, the new organisational identity was linked with a community-oriented work-style. Change and growth was not only in numbers of patients and facilities but in the organisation's development.

NGOs: stages of growth and development

Korten in his comprehensive study of NGOs analyses their growth and possible further development by tabulating what he calls "generations" (1990: 117, see Table 5.1). This analysis may legitimately be cited in regard to health NGOs, as a sub-set of the general NGO category, whether INGOs or CYNGOs, according to Matthias and Green's definitions.

However before suggesting where ARC/PHC or its successor FPHC might be located in this generational table, it is appropriate to provide a fuller picture of health-oriented NGOs in general by citing their advantages and disadvantages, and how they fit into the NGO picture in Pakistan. This picture includes those NGOs involved with health care for refugees, of which ARC/PHC/FPHC is one, and what advantages and disadvantages it displayed.

Table 5.1 Strategies of Development-Oriented NGOs: four generations

GENERATIONS				
	FIRST <i>Relief and Welfare</i>	SECOND <i>Community Development</i>	THIRD <i>Sustainable Systems Development</i>	FOURTH <i>People's Movements</i>
Problem Definition	Shortage	Local Inertia	Institutional and Policy Constraints	Inadequate Mobilising Vision
Time Frame	Immediate	Project Life	10-20 Years	Indefinite Future
Scope	Individual or Family	Neighbourhood or Village	Region or Nation	National or Global
Chief Actors	NGO	NGO plus Community	All relevant Public/Private Institutions	Loosely Defined Networks of People/Orgs.
NGO Role	Doer	Mobiliser	Catalyst	Activist/ Educator
Management Orientation	Logistics Management	Project Management	Strategic Management	Coalescing and Energising Self-Managing Networks
Development Education	Starving Children	Community Self-help	Constraining Policies and Institutions	Spaceship Earth

Source: Korten 1990:117

Health-oriented NGOs: advantages and disadvantages

Advantages

Green and Matthias quote the following as features of health NGOs usually regarded as positive:

- they are closer than the government to the poor
- their staff are well-motivated and altruistic
- they are economical in operation
- they are flexible and quick in response (1997: 45)

Green and Matthias mention the distinction between NGOs as a sector and individual NGOs, and see the four features above as rather sweeping generalisations (1997: 59). The four features are apparent at FPHC, but with some modifications, in keeping with Green and Matthias' observation.

Firstly, FPHC's target population consists of poor people—refugees and villagers. The NGO further demonstrates closeness to the poor by using volunteers from local refugee and village communities, unlike GOP. Many FPHC staff are themselves refugees: in the early years, 90% of staff were refugees, many resident in the camps, as noted in Chapter 3. Chapter 3 also comments on the loyalty of long-serving staff as evidence of motivation, the second characteristic noted above. However, it is possible that motivation may have varied across different organisational levels. Chapter 6 notes that the Director and his wife had both turned down offers of better-paid jobs—evidence of altruistic motivation; the security offered by the health project at the time of ARC's demise in 1993/94 may have been a more significant consideration for junior staff. Thirdly, costs were apparently kept low:

“Total gross cost of organisation in 1994 divided by number of people registered gives an expenditure of Rs 182 per person in the population served...Adding BHU attendances and home visits together, the cost of one episode of consultation between a patient and one or more members of staff in 1994 was Rs 50...Costs of drugs and dressings in 1994 was about Rs 20 for each person registered” (FPHC: Application to SAP/PDP Phase I: 1995: 12)⁴

But this quotation hides the costs of donated drugs, medicines and equipment. Using volunteers helped to reduce expenditure, but is perhaps more illustrative of the organisation's ability to attract community resources. Finally, FPHC demonstrated flexibility by its adoption of a new identity and work-style; it also demonstrated flexibility and rapidity in its PHC project days by prompt setting up of a temporary BHU outside Jalalabad in response to the sudden 1992 exodus of Afghans from Kabul after the Najibullah regime collapsed.⁵ Also, when more distant villages began to ask FPHC to set up Health Centres—impossible without adequate funding—FPHC responded positively by sending teams from its Human Resources Unit to train local volunteer health workers.

Green and Matthias also seek to distinguish between a comparative advantage for NGOs resulting from a *current* situation, e.g. where the public sector is weak and in theory improvable (1997: 46) and possible *intrinsic* advantage for NGOs as health providers. They conclude that as a sector, NGOs have none of the latter, but they agree that under certain circumstances individual NGOs may possess a comparative advantage (1997: 61). Chapter 4 demonstrated GOP's failure to provide: Kagan villagers' action in opting for ARC/PHC in 1988 may have reduced pressure on government to improve its service. This situational advantage strengthened ARC/PHC's position and created a new opportunity.

⁴ Calculations by JSP: the application to SAP/PDP Phase I was compiled jointly by MMP and JSP; at the time the rate of exchange was approximately Rs 45-50 = £1.

⁵ The special organisation of the Jalalabad BHU is described in Chapter 3

The four positive features listed above, particularly the first two, appear in the case of FPHC to be size-related; that is to say, intimate working relationships can be more easily maintained if an organisation does not grow too large either numerically or geographically—perhaps in the NGO field, small—and compact—is beautiful. All FPHC staff live locally, in the camps or villages, or in or near Mardan. ARC as an umbrella organisation developed serious management and supervision problems with cross-border work inside Afghanistan and even within Pakistan (personal communication January 2003 from former Depute Director ARC), partly because of distance and partly because it had taken on a wide range of activities and a large body of staff—over 300 at its maximum around 1991 (ARC Annual Report: 52). The health project, by contrast, established itself as virtually static, geographically and numerically, and administratively self-contained, as explained in Chapter 3. Under a strong leader having a close affinity with the community (sufficiently motivated to remain in post for 13 years), it underwent a kind of "localising" process. His successor is also a Pathan, but a Pakistani with significant local connections, as described in Chapter 6. His relationship with staff is close, for he had served as a Team Leader in the health project since 1988.

Disadvantages

The positives identified by Green and Matthias seem to be more applicable to CYNGOs, perhaps especially to very localised ones, rather than to INGOs. But, they say, there are other characteristic aspects of NGOs both international and in-country which may be criticised as negative and/or disadvantageous:

- management may be responsible to the committee of Trustees or Governors, but to whom is the committee responsible?
- insistence on independence and autonomy may affect capacity to work with government and with other NGOs
- interests and activities can overlap, leading to duplication, rivalry and destructive competition between NGOs
- NGOs can become isolated; their policies may affect the balance of equity in the country as a whole (1997: 49)

Some of these criticisms can be applied to ARC and FPHC e.g. the External Evaluation criticised the "*weakness*" of FPHC's Board of Governors (1998: 7); the earlier Evaluation had alerted management to the risk of isolation; informal conversations with management confirmed wariness of too close a relationship with GOP (field notes). Duplicating the service of any other NGO however seems unlikely, as noted later in this chapter.

There are writers (Key and Sims below) whose comments on NGOs in Pakistan link with these substantial criticisms by Green and Matthias and are shared by health oriented NGOs as a sub-set. Before discussing their findings, it is useful to understand the background to the NGO sector in Pakistan.

The NGO scene in Pakistan: legislation

The definitions of NGOs proffered by Green and Matthias and quoted early in this chapter mention NGOs as "*outside the control of government*" and "*with a decision-making authority independent of government*". In spite of apparent distance and autonomy, a relationship with government does exist, of a formal kind, based on legislation. In other words, governments tolerate NGOs, and much as the voluntary sector stresses its independence, it is obliged to government for its existence.

In the Indian sub-continent, long before partition in 1947, the colonial power was interested in voluntary action across a wide field, not only health. Four out of the six legislative tools (some from the nineteenth century) available to NGOs seeking registration date from pre-independence and are still in force, suggesting that GOP policy on voluntary activity has changed little since colonial times. The terms of the legislation under which NGOs can be registered in Pakistan are so broad as to be apparently elastic, but they are also confusing and make it difficult for an NGO wishing to be registered to know under which statute to apply.⁶

But toleration of NGO activity is not necessarily to be confidently presumed as universal. An additional and fairly recent piece of legislation is the Companies Ordinance of 1984, considered as one option for FPHC's proposed registration. In the 1990s some external donors showed a preference for this to be used by NGOs contemplating registration, probably because its financial sections were strict (conversation with Field Director, Oxfam Pakistan 1994). Legal advice to FPHC however was to apply under The Societies Registration Act as favouring its autonomy; the 1984 Ordinance gave GOP the power to close down "companies" thus registered. Most of the legislation however is permissive, implying many possible fields of activity and many actors in the NGO sector in Pakistan. The reality is very different.

⁶ 1. The Societies Registration Act 1860
2. The Charitable Endowments Act 1890
3. The Trust Act 1882

4. The Co-operative Societies Act 1925
5. The Voluntary Social Welfare Agencies Ordinance 1961
6. The Social Welfare Agencies Act 1987

The NGO scene in Pakistan: reality

In deprecating the scarcity of information about NGOs in Pakistan (i.e. of any kind, including health-oriented NGOs) Sims quotes a UNDP study:

"There may be as many as 4833 NGOs in Pakistan, but it listed only 1018. Others had dissolved or could not be found. Almost no published information is available about the men and women associated with the NGOs cited in the UN study, which provided only names and addresses." (1997: 204)

Sims declares that the proportion of NGOs in Pakistan is significantly lower than in neighbouring countries (1997: 213). She alludes to work by Key (1990) who attempted a comprehensive investigation under the title "The Politics of Voluntarism in Pakistan". He records similar difficulties in assembling accurate information. In eight months in Pakistan, he was able to make meaningful contact with only 24 voluntary organisations, in spite of having addresses, telephone numbers and names of allegedly responsible individuals for many more. Travel and communication difficulties commonly encountered in Pakistan restricted his research to the major cities of Islamabad, Karachi and Lahore, with one trip each to Peshawar in NWFP and to Quetta, capital of Baluchistan. His sources of NGO data were the registration lists held under the various statutes, and also lists maintained by donor organisations. He concluded that

- lists of NGOs under the various statutes are not accurately maintained
- there is no single central monitoring body.
- most NGOs were urban-based
- NGOs are small and lack dynamism
- most NGOs are as reluctant to work in remote areas as any other agency.⁷

Although Key's research is over ten years old and has not been updated (personal communication to MMP 2001), the uncertain reputation of the NGO sector in Pakistan has persisted.⁸

⁷ The Aga Khan Programmes in the Northern Areas may appear to contradict this observation, but this is the homeland of the Ismaili sect, who are their target population.

⁸ Zia Rizvi of IBHI (Independent Bureau of Humanitarian Issues) who was commissioned by the Austrian Chancellery to carry out the first external evaluation of ARC was of the opinion that 90% of the NGOs in Pakistan were ineffectual (conversation with MMP/JSP in 1994).

Pakistan NGOs: distribution, size, interests, environment and typology

Distribution

As evidence of the uneven distribution of NGOs across Pakistan, Sims refers further to the UNDP study. Baluchistan and NWFP were home to only 4% and 3% respectively of the total number of NGOs, but it is difficult to know how to interpret this, given that the overall figure of 4833 was not considered a true one (1997: 207). It can be deduced however that there is less NGO activity in the provinces of Baluchistan and NWFP, in view of Key's (and Sims') observation that NGOs are mostly urban-based; these two provinces are predominantly rural. The restrictions in NWFP on the movement of women affect not only their access to health care but their potential involvement in voluntary activity: virtually half the adult population of NWFP is therefore excluded from the resource/activist pool.

Size

Sims notes that NGOs in Pakistan range from very small *ad hoc* groups to large highly structured organisations (1997: 207). Many of the former will be Community-Based Organisations (CBOs) which are local bodies, many unlikely to be registered.⁹ The 24 NGOs studied by Key covered several fields—rural development, education/literacy, women, socio-economic research, sport—but only four were health-related. These were specialist i.e. a hospital, a drug-abuse agency, and MCH/Family Planning. None mentioned primary health care, though it is possible (though not stated) that some included one or two PHC components in their services. Sims quotes the UNDP survey of 1991 as noting that many NGOs surveyed were involved in social welfare activities including health, but she does not elaborate.

Environment

Key's study appears as intensive as was possible given the constraints. He analyses the environment in which NGOs flourish—or do not.¹⁰ The parameters are political openness and low state dominance. He rates Pakistan as a politically closed society, with low state dominance, features associated with military governments and the prevalence of patronage. In contrast to the relatively open society of the UK where the state has a prominent role and there is a lively voluntary sector, both of these features—militarism and patronage—persist in

⁹ For instance, a long-serving member of FPHC's staff (a Pakistani) runs a small CBO (independent of FPHC) which collects money and distributes small sums to the needy. How decisions are made is not clear, but practice seems to be along traditional charitable lines.

¹⁰ Although Key made contact with only 24 NGOs, he was able to visit a number of these several times.

Pakistan. They are not favourable to a vigorous NGO sector, nor as previously outlined in Chapter 4, to provision of basic services for the majority of the population.

Typology

Key develops a typology of NGOs in Pakistan. To summarise :

- **“Insider” NGOs:** have a characteristically formal structure, closed membership and decision-making; have strong links with the elite and the political status quo. They display extreme personalism, almost "ownership" of the NGO by an individual—a *begum* perhaps—or a family, disbursing social welfare assistance as funds allow—often from government sources. Some "Insiders" rely on their influence and contacts and dispense with registration.¹¹
- **“Entrepreneur” NGOs:** seek to effect positive social change in "*seemingly neutral*" areas (Key's phrase, rather at odds with the implicit political activity of health NGOs) such as health, sanitation or education (1990: 223). They are more professionalised, but they do not have the influence or contacts of the "Insider" NGOs. They operate in a rational-functional manner, and employ paid staff. They tend to look for funding from external donors, because government favours "Insiders".

This “Entrepreneur” description appears to fit FPHC, because of its health orientation and also because of its organisational style. In 2000, as well as using volunteer health workers, it employed 115 experienced and trained staff, of whom nine were qualified doctors (5 men, 4 women). Other members of staff like the LHVs and the Malaria Supervisor held qualifications from the Health Services Academy in NWFP. The Administrator was army-trained and a graduate. Other middle-grade workers had been trained within ARC/PHC/FPHC itself. Chapter 3 noted its built-in systems of staff supervision and record-keeping. Accounts are audited annually by a professional firm of accountants. The NGO was largely dependent on external donors.

Key's two other groups of NGOs, **Outsiders** and **Puritans**, he considers somewhat alienated from Pakistan society. "Outsider" NGOs tend to have the skills of journalists, social scientists and lawyers, operating like "think tanks" (p 228) and adopting a questioning rather

¹¹ Links with the elite are not always negative features: Sims quotes Begum Liaquat Ali Khan, wife of the then Prime Minister who founded several NGOs, including APWA (All Pakistan Women's Association) soon after partition in 1947. These NGOs mostly benefited educated middle-class and professional women, though APWA promoted some health care for poor women.

than a confrontational attitude to the state.¹² They may conduct research, provide legal defence in unpopular causes and may have some paid staff. They are careful to conform to legal requirements. "Puritan" NGOs are even more alienated, do not register, and behave as pressure groups. Further discussion of these last two groups is not relevant to this case study. Key suggests there may be overlaps between the types he identified, and that movement from one to another is possible, notably from "Entrepreneurs" to "Insiders".

Another category of voluntary activity

The Pakistan NGO field is not without pioneering individual citizen activists, such as Dr. Akhtar Hameed Khan who worked both in the former East Pakistan (now Bangladesh) to set up the Comilla Project, and later to set up the Orangi Pilot Project in Sindh. Neither is primarily a health enterprise but they are often quoted as co-operative social movements which have improved the quality of life for participants. Enlightened activists set up the Family Planning Association of Pakistan in the early 1950s, being concerned about GOP's apparent lack of interest in Pakistan's emerging population problem.

A discrete category of NGOs in Pakistan

In setting the NGO scene in Pakistan, like Key and Sims I have so far in this chapter (apart from a few mentions of ARC/PHC/FPHC) ignored a substantial category of NGOs, that is, NGOs concerned with the camp population in NWFP where most of the Afghan refugees remain. There are also refugees in Pakistan originating from other localities, notably Kashmiris. Sims and Key's work disregards not only NGOs working with refugees, but makes no mention of the presence of refugees at all. Yet their writings refer to a period when the refugees were even more numerous and refugee-related activities more visible than they are today. Perhaps useful information, even comparisons, might have surfaced if the research had included some refugee-oriented NGOs. Such organisations would almost certainly have been easier to contact, since UNHCR maintains basic information on its partner NGOs.

Other research by Khan (1994) addressing future planning (by Federal or Provincial GOP), including health, for the regional role of Peshawar, also ignores (at least in the thesis abstract) the substantial health work in NWFP managed from Peshawar by GOP/UNHCR's Afghan Refugee Health Programme. Research by Chakrabarti, Rutter and Worley in 1987 for ODA makes mention in passing of NGOs working with the Afghan refugees. Mission

¹² The Social Policy and Development Centre, Karachi (SPDC) describes itself as an independent and non-partisan private sector institution providing policy-relevant research on social development in Pakistan. Its registration status is not stated in its Annual Reports of 1995 and 2000, but its activities suggest it belongs to Key's "Outsider" category.

time-limits did not allow them to examine these, but they say that they would like to do so at a later date. The later study by Lafond and White "Sustainability in the Health Sector in NWFP" commenting on

"the limited role of NGOs, especially in the health sector, where they provide 1% of the total health resource" (1993: 39)

makes no mention of NGOs working with refugees; the 1% presumably refers to the service available to the Pakistani population of NWFP.

Health-oriented NGOs working with Afghan refugees

There is however research by Godfrey spanning the years 1978-88 specifically on those NGOs providing health care to Afghan refugees as partners within the Afghan Refugee Health Programme of UNHCR/GOP. Godfrey's title to her comprehensive 1993 study refers to *"the multiplicity"* of responses by the international community via NGOs, some like ARC created as a direct response to the emergency of 1979-80. The Programme was organised on a provincial basis, but the NWFP Programme was the largest, and according to Godfrey the best managed. Chapter 3 of this thesis outlined the various responsibilities undertaken by these NGOs as partners with UNHCR. There were ten in 1980, and more by 1984—see Table 5.2.

Margaret Usher, who had been in charge of the CHW training for the Refugee Health Programme in NWFP, was very positive about refugee camps as appropriate sites for the promotion of the PHC strategy, (apart from its being an essential service) and especially by NGOs, because

- a refugee camp has a defined population
- NGOs are relatively rich
- NGOs have better access to external advice
- NGOs have better equipment and supplies
- NGOs have their own infrastructure (interview Geneva 26.11.02)

She supported the notion of camp residents as a "demonstration population", just as in effect the 1993/4 External Evaluation of ARC/PHC had done, basing its conclusions and recommendations about the project's development potential on data about a defined refugee target group and the work done with them.

Table 5.2

Charitable agencies recognised by Pakistani authorities for providing health care for the Afghans in 1984 (excluding hospital services)

AGENCY	COUNTRY OF LEGAL REGISTRATION	HEALTH SERVICES PROVIDED
<u>North West Frontier</u>		
Austrian Relief Committee for Afghan Refugees	Austria	2 basic health units
CARITAS Pakistan	Pakistan/Holy See	donations of food and other material goods
German Agency for Technical Cooperation	West Germany	not specified
Inter Aid Committee	Pakistan/United States	7 basic health units
International Committee of the Red Cross	Switzerland	first aid posts
International Rescue Committee	United States	6 basic health units
Islamic African Relief Agency	Sudan	not specified
Italian Cooperation for Development	Italy	management and funding of tuberculosis control programme (NWFP)
Kuwait Red Crescent Society	Kuwait	3 basic health units
Norwegian Refugee Council	Norway	not specified
Pakistan Red Crescent Society	Pakistan	1 basic health unit; specialty care
The Salvation Army	United Kingdom	3 basic health units
Saudi Red Crescent Society	Saudi Arabia	8 basic health units
Save the Children Fund	United Kingdom	3 basic and sub- health units; training

(contd. on next page)

Table 5.2 (contd).

Charitable agencies recognised by Pakistani authorities for providing health care for the Afghans in 1984 (excluding hospital services)

AGENCY	COUNTRY OF LEGAL REGISTRATION	HEALTH SERVICES PROVIDED
Swedish Committee for Afghanistan	Sweden	not specified
Serving Emergency Relief and Vocational Enterprises (SERVE)	United Kingdom	eye clinic
Union Aid for Afghan Refugees	West Germany	17 basic and sub- health units
<u>Baluchistan</u>		
Action International Contre La Faim	France	2 basic health units
Inter Aid Committee	Pakistan/United States	3 basic health units
International Committee of the Red Cross	Switzerland	2 first aid posts
Pakistan Red Crescent Society	Pakistan	not specified
Saudi Red Crescent Society	Saudi Arabia	3 basic health units
<u>Punjab</u>		
Austrian Relief Committee for Afghan Refugees	Austria	sanitation
18 Agencies	14 countries	58 basic and sub- health units; first aid; specialty care; funds; information

Source: Godfrey 1993: 335, 336

Omission of the refugee NGOs from research by Key, Sims and others reflects the exclusiveness of arrangements for coping with refugee basic health needs. As in many refugee situations, the Afghans' stay was expected to be temporary. From the time of the major influx into Pakistan in 1980, the UNHCR/GOP partnership viewed the Afghan Pathans as distinct from the generality of the population of Pakistan, in spite of their ethnic, religious and linguistic kinship with the Pakistani Pathans of NWFP. Separate arrangements seemed to make sense when refugee numbers suddenly grew beyond the capacity of GOP's existing health care service for its own nationals, as explained by Col. Altaf-ur-Rahman

Khan (see chapter 3). Separation of health care was linked to the separate living arrangements (the camps) set up for refugees in 1980. Each refugee BHU was intended to serve 10-15,000 people.

Van Damme, on the other hand, writing on government provision in Guinea for refugees from Liberia is critical of the practice of accommodating refugees in camps. He argues for absorption into the population and existing government health facilities, stressing the dangers associated with overcrowding and the fostering of passivity and hopelessness in camps. He avers that the bigger the camps are, the more pronounced these effects become, but he concedes that

“preventive care delivery is operationally much easier among a captive target population in a camp than among self-settled and inadequately registered refugees as in Guinea” (1998: 189).

These acknowledgements by Usher and Van Damme of the “captive” (even if not literally so) and bounded nature of camps as facilitating preventive care supports the generally positive reputation of the Afghan Refugee Health Programme. There are some very large camps in NWFP, for example Shamsatoo which I visited (pop. 70-80,000) and Katcha Gari on the outskirts of Peshawar (c.100,000) to which Van Damme’s more negative comments may apply.¹³ The official standard of one basic health facility per 10-15,000 refugees means there may be several BHUs in these large camps, run by different agencies (as was the case at Shamsatoo) with a potential for rivalries and disagreements. On the other hand, no camp served by ARC/PHC/FPHC was larger than Gandaf at 15,000 in year 2000. Senior FPHC staff felt strongly that providing their full range of health care programmes on the basis of one Health Centre to each of the camps they serviced was quite feasible: the 1993/4 Evaluation’s positive findings support this. 10-15,000 is also the standard target population of GOP BHUs, but this is not always adhered to¹⁴.

Regarding the creation of a separate health service for the Afghan refugees, (much more numerous than the Liberians in Guinea) Godfrey alleges a political motivation on the part of GOP. These settlements, as well as facilitating distribution of relief services, were organised, she says, in order to discourage integration with Pakistani people, and consequently long-term settlement in Pakistan (1993: 308). However, GOP did not go as far as to impose any restriction on movement by the refugees in and out of the camps. The Federal Government of Pakistan has long been wary of Pathans in general, recognising their fierce independence, well known to the colonial administration in its time. This independence

¹³ Deputy Project Director (Health) of the Refugee Health Programme saw Katcha Gari as an accident waiting to happen, because of serious drainage problems. Remedial plans had to be postponed when the “drought” wave of refugees began in 1999.

¹⁴ Table 6.2 in the next chapter quotes target populations of 16,500 and 19,500.

endures particularly in the tribal areas, where carrying arms is quite usual, and which still abide by their own traditional laws in preference to the Pakistani system of jurisdiction based on the inherited British model. The possibility of creating "Pukhtunistan" for all Pathans has a history going back to the 1920s and 1930s (see Banerjee 2000); Pukhtun regionalism is still a serious topic of discussion (Kukreja 2003:125-130).

Supporting, staffing and shaping basic health care for refugees

The exception to this separateness of health provision was (and is) the availability of GOP secondary medical care to Afghans. Additionally, out-patient facilities for basic health care are open to refugees in the immediate area at the three GOP hospitals in Peshawar, to which GOP allocates special annual subsidies (interview with CAR–Commissioner for Afghan Refugees–in Peshawar, 2001). Reciprocal use of GOP and Refugee Health Programme BHUs by refugees and local Pakistani villagers is believed to occur quite widely, but no figures were kept, according to the Programme Officer (Health) of UNHCR and also according to fieldwork evidence in 2002. The practice does not detract from the official separateness of the two basic health care services.

Another cross-over point between GOP service and service to refugees is that one employment option for newly qualified doctors from Pakistan medical schools is the Refugee Health Programme—in 1988 there were 11,000 of these doctors (Lafond and White 1993: 20). This is admitted to be one way of coping with the over-production of doctors in Pakistan (Jamil 1993: 54), a convenient means of shelving a problem and pacifying a vocal profession. Almost all Refugee Health Programme Medical Officers are Pakistanis, the very few others being Afghans who have worked in the Programme for up to 20 years.¹⁵

Godfrey traces the policy of employing Pakistani doctors back to the GOP's national health plan of 1976-81 (1993: 318). This plan called for one BHU for every 10,000 persons (i.e. Pakistani nationals) to be staffed by paramedicals, suggesting a PHC orientation. But a special committee appointed by the President to investigate the surplus of doctors recommended that doctors be placed in these BHUs rather than paramedicals. I would argue that the preference for medical professionals determined the staffing shape of the team-based new health care system set up via the GOP/UNHCR Refugee Health Programme. From its earliest days as a mobile service with very small teams of 2-4 people, basic health care for the refugees was doctor-led—as it was at ARC/PHC, in keeping with the evolving Refugee Health Programme practice.

¹⁵ Interview with Depute Project Director (Health) April 2001, and with one Afghan MO at Shamsatoo camp BHU April 2002.

Continuing turmoil within Afghanistan throughout the 1980s and 1990s reduced the likelihood of the refugees' return home, although a substantial number did go back *en masse* in 1992. Need for health care to refugees in Pakistan continued. The number of NGOs involved in caring for Afghans had by 1989 mushroomed to 70, some of which worked in both Afghanistan and Pakistan, a few in Afghanistan only (Godfrey 1993: 382-385; table 5.3). Medical relief in the earliest days of the Afghans' stay in Pakistan had, well before 1992, moved into the more development-oriented Refugee Health Programme incorporating its partner NGOs.

The policy agrees with a personal observation by Dr. John Seaman, senior medical officer at SCF (interview in London July 2001) that once the initial emergency has passed, health needs of refugees are no different from health needs of other poor people in developing countries, in this instance the local rural population of NWFP. But for the duration of the refugees' stay, the local population has officially depended on the less-than-effective service provided by GOP, alongside the Refugee Health Programme. The latter did not seem to have had any effect on GOP's basic health care practice.

Two discrete health services in NWFP

Godfrey is explicit about the separate and parallel nature of the two health care services operating in NWFP:

"There was little co-ordination between the refugee health programme and health services provided by GOP for its own people. Although the refugee health programme was built around the same interventions which were given priority in the ongoing health services of the GOP, separate lines of accountability for managerial and political authority, different systems of remuneration and working conditions for health personnel, the participation of a host of foreign relief agencies and access to vast sums of money and material goods for refugee relief through various institutions of the international community enabled the refugee health programme to function independently. Not only did these and other factors influence the development of a parallel system of health services which functioned in isolation from other systems of health care in Pakistan, they contributed to the creation of a system of health services which consistently provided a higher quality of care. Unlike ongoing health programmes of the Provincial governments which continued to be under-resourced, insufficiently staffed and poorly managed measures were taken to overcome these obstacles and others early in the development of the refugee health programme. This meant that health services for the refugees ensured that basic care of a quality acceptable to the GOP and international aid agencies alike was available on a regular basis" (1993: 419).

Table 5.3

**Organisations providing health care for Afghans from the North West Frontier
1989**

AGENCY	NATIONALITY	BEGAN	1	2	3
1.Afghan Refugee Leprosy Service	UK	/86	N	N	P
2.Afghan Health and Social Assistance Organization	Germany/ Netherlands/ Afghanistan	1/87	Y	Y	B
3.Afghan Medical Aid	Pakistan	11/89	Y	Y	B
4.Afghanistan Nothilfe	Germany	1/87	N	N	B
5.Aide Medicale Internationale	France	9/85	N	Y	B
6.Afghan OB/GYN clinic	Afghanistan	11/84	Y	Y	B
7.Austrian Relief Committee for Afghan Refugees	Austria	1/80	Y	Y	B
8.Afghan Relief Foundation	Afghanistan	/87	N	N	B
9.Afghanistan Vaccination/ Immunization Centre (AVICEN)	France	9/87	Y	Y	B
10.Afghan Refugees Humanitarian Unity	Afghanistan	7/85	Y	N	?
11.Afghan Welfare Centre	?	/86	N	N	?
12.CARITAS Pakistan	Pakistan	/80	Y	Y	P
13.Catholic Relief Services USCC	US	/85	Y	Y	P
14.Christian Hospital Extension Programme (CHREP)	Pakistan	/85	Y	Y	P
15.Committee for a Free Afghanistan	US	/86	Y	Y	P
16.Danish Committee for Aid to Afghan Refugees	Denmark	1/84	Y	Y	P
17.Dental Clinic for Afghan Refugees	Afghanistan	1/84	N	N	B

Contd. on next page

Table 5.3 (contd).

AGENCY	NATIONALITY	BEGAN	1	2	3
18.Dorsch Consult	?	/86	N	N	P
19.Freedom Medicine	US	2/86	Y	Y	B
20.German Afghanistan Committee	Germany	8/85	Y	Y	B
21.German Afghanistan Foundation	Germany	7/87	Y	Y	B
22.German Technical Cooperation GTZ	German	/85	Y	Y	P
23.Hayat Services	?	/85	Y	Y	?
24.Human Concern International	Canada	1/89	N	N	B
25.Human Concern Relief Fund	Canada	/85	Y	Y	?
26.Help the Afghans Foundation	Netherlands	/85	Y	Y	B
27.Help Organization of West Germany	Germany	/86	Y	Y	P
28.Inter-Church Aid	Pakistan	11/79	Y	Y	B
29.Idara-e-Ahya-ul-Uloom	Pakistan	/80	Y	Y	?
30.International Committee of the Red Cross	Switzerland	/80	Y	Y	B
31.International Medical Corps	US	11/85	Y	Y	B
32.International Rescue Committee	US	6/80	Y	Y	B
33.Islamic Relief Agency	Sudan	/84	Y	Y	B
34.Italian Cooperation for Development	Italy	/84	Y	Y	P
35.Kuwait Red Crescent Society	Kuwait	/84	Y	Y	P
36.Japan Afghan Medical Service	Japan	/86	N	N	P
37.Lajna Al-Dawa Al-IslamiP	uwait	/87	Y	Y	B

contd. on next page

Table 5.3 (contd).

AGENCY	NATIONALITY	BEGAN	1	2	3
38. League of Red Cross and Red Crescent Societies	Switzerland		Y	Y	P
39. Medecins Sans Frontiers	Belgium	11/88	Y	Y	B
40. Medecins Sans Frontiers	France	1/87	Y	Y	B
41. Medical Refresher Course for Afghans	France	9/85	Y	Y	P
42. Management Sciences for Health	US	11/87	N	N	B
43. Muslim Aid	UK	6/86	Y	Y	B
44. Mercy Fund	US	7/87	Y	Y	B
45. Muslim World League	Saudi Arabia	/86	Y	N	?
46. Norwegian Refugee Council/ Norwegian Church Aid	Norway	/80	Y	N	B
47. Pakistan Red Crescent Society	Pakistan	/80	Y	Y	P
48 PP-German Basic Education	Germany	/86	N	N	P
49. Psychiatry Centre for Afghan Refugees	?	?	Y	Y	P
50. Rabita Al-Alam Al-Islami	Pakistan	/88	Y	Y	P
51. Saudi Arabian Red Crescent Society	Saudi Arabia	/80	Y	Y	B
52. Swedish Committee for Afghanistan	Sweden	1/84	Y	Y	B
53. Save the Children Fund	UK	/80	Y	Y	P
54. Sandy Gall Afghanistan Appeal	UK	4/88	Y	Y	?
55. Shelter Now International	Australia/ Sri Lanka	10/88	Y	Y	B
56. Serving Emergency Relief and Vocational Enterprises (SERVE)	UK	9/80	Y	Y	B
57. Salvation Army	UK	/84	Y	Y	B

contd. on next page

Table 5.3 (contd).

AGENCY	NATIONALITY	BEGAN	1	2	3
58. Seventh Day Adventists	Pakistan	/86	Y	Y	P
59. Society of Afghan Doctors and Other Health Professionals outside of Afghanistan	Afghanistan	/80	N	N	B
60. Solidarites Afghanistan	Belgium	6/84	Y	Y	B
61. Solidarites Afghanistan/Gilde de Raid	France	/86	N	N	B
62. Union Aid for Afghan Refugees	Germany	/80	Y	Y	B
63. Union Aid of Afghan Mujahid Doctors	Afghanistan		Y	Y	B
64. United Arab Emirates Red Crescent Society	UAE	/88	Y	Y	?
65. United Medical Centre of Afghan Mujahid Doctors	Afghanistan	/82	N	N	B
66. Welfare and Relief Committee for Afghan Refugees	Afghanistan	9/87	N	N	B
66 Agencies					
<u>Agencies which acknowledge work in Afghanistan only</u>					
1. Action Internationale Medicale Etudiante	France	8/81	N	N	A
2. Mercy Corps International	US	5/87	N	N	A
3. Medecins du Monde	France	2/80	N	N	A
4. Norwegian Committee for Afghanistan	Norway	3/85	Y	Y	A
4 Agencies	3 countries	1980 - 87			
70 Agencies in health					

1. Location of projects: Pakistan (P), Afghanistan (A) or both (B)
2. Recognised by officials of the refugee health programme: Y (Y) or No (N)
3. Registered with the Government of Pakistan: Y (Y) or No (N)

Source: Godfrey 1993:382-385

Since Godfrey's comments are concerned with the years 1978-88, it may be thought that they are not particularly relevant to the situation in the 1990s. Financial support to the refugees dwindled considerably after the end of the Cold War—or "proxy war", Afghanistan having been the proxy battlefield. But after the post-Najibullah return home in 1992, one and a half million remained in camps in Pakistan, and another 500,000 were distributed throughout the Pakistani population. The Refugee Health Programme continued, in spite of the departure of some partner NGOs, separate from the service provided by GOP, retaining its reputation for greater effectiveness and efficiency, and also retaining some NGO partners (see table 5.4). As late as 2001 and 2002, this positive perception of the Refugee Health Programme was borne out in many informal conversations and interviews in NWFP and Islamabad. For example:

1) A senior doctor at Trust for Voluntary Organisations (TVO) declared to me in April 2001 that camp people were healthier because they were "*environmentally advantaged*": they had health-related benefits of safe water supply, sanitation and electricity, all ultimately the responsibility of UNHCR and the Commissioner for Afghan Refugees. Pakistani villages are by no means universally supplied with all or any of these amenities. Women in Baghicha village complained to me that the communal latrine for their use was inadequately screened; the village men used the fields. They also complained that the communal water tank was too far from their houses. Many families in Wardaga village used canal water for all household purposes including drinking.

2) The MO and LHV of a GOP BHU in Mardan District interviewed in April 2002 confirmed the continuing positive reputation of the Refugee Health Programme. Staff and patient morale at this GOP BHU was markedly low, as was patient attendance; windows, doors and floors needed repairs; staff reported the usual supply problems. Both staff had previously worked for the Refugee Health Programme and affirmed that facilities, equipment and service to Programme patients were superior. Both justified their choice to move to GOP service "*because it is a permanent job with regular pay and a pension*", but made no mention of job satisfaction. The official impermanence of the Refugee Health Programme means that employment contracts are annual; this is presumably of less concern to newly qualified graduates than to older persons with greater family responsibilities.

Table 5.4

Implementing Partners (charitable agencies) providing services (including health) to Afghan refugees 2001

Agency IPs	Name	Title	Sector/Activities	Phone No.	Fax	E-mail
AMWA	Dr. Nasir Sherzad	Director	Health	42888	840784	
CWS	Mr. Douglas R. Beane	Director	Health	0598-37118		
DACAAR	Mr. Thomas Thomson	Director	Water	40731	840516	
FPHC	Dr. Emel Khan	Programme Manager	Health	0931-63837	61403	
GTZ-BEFARe	Mr. Ulf Bartholomae	Director	Education	840631	841047	
HINI	Mr. Dennis de Peorck	Director	Health	844474	840379	
IRC	Sigurd Hanson	Country Director	Health/Water	40973	840283	ircgp@netzone.net.pk
KJRC	Dr. Ahmad Al-sanousi Ahmad	Director	Health	840345	840521	
OLW	Ms. Shahnaz	Representative	Education	40410	841219	
PRCS	Group Capt. Hassan Raza	Director	Health	844387		
SCF/IUS	Ms. Vicki A Dean	Programme Advisor	Health	60192	610192	
SAWS	Ms. Lisa Lundgren	Country Representative	Community Services	840987	840349	radda@brain.net.pk
SJAWO	Haji Ghulam Dastagir	Director	Vocational Training	42763	840882	
UAAR	Dr. Muntazir	Director	Health	43609	844968	
CAR	Mr. Naeem Khan	Commissioner		9217083	9217076	
PDH	Dr. Javed Pervez	Project Director Health	Health	277046	271762	
EDUCATION CELL	Mr. Iftikhar-ul-Mulk	Addl. Commissioner	Education	9216465		
SWC	Mr. Ali Gohar	Addl. Commissioner	Community Services	9217051		

Source: UNHCR Office Peshawar March 2001

The continuing separation and parallelism of the two health care services means that GOP (Federal and Provincial) and Health Department senior personnel needed to take no interest in the Refugee Health Programme nor in activities of participating NGOs. Nor, as Godfrey remarks, did they have on their agenda its sustainability as a future resource (Godfrey 1993: 342, 438-9). FPHC was aware of the danger of its own potential isolation, as warned by the External Evaluator in 1993/4.¹⁶ Godfrey suggests several options for integrating refugee health services into GOP provision, but is not optimistic about any because of a lack of political will and poorly developed national health structures. She foresaw disintegration of the Refugee Health Programme (1993: 442). But the Programme continues as a functioning, still separate and parallel service. The need for refugee health care has persisted beyond year 2000—even increased after the “drought” influx of 1999 and later.

NGOs and GOP

Key's (1990) findings of poor maintenance of registration lists and no central monitoring are evidence of Federal and Provincial Governments' lack of interest in NGOs and in developing some co-operative relationship at that time, “Insider” NGOs occupying an exceptional and privileged position. If GOP was interested in NGOs as a resource, this would be an incentive to improved record-keeping. Key's assessment of “Entrepreneur” NGOs as more professionalised, as I believe FPHC to be, suggests that some of these, if health-oriented, could be a resource as indicated in the Alma Ata Declaration. But, he says, they are disadvantaged because they are not close to the elite and find it difficult to get a hearing. Two examples follow:

1) As part of the 1994-95 process of transforming itself into a Pakistan-registered NGO, ARC/PHC needed to acquire contacts outside UNHCR and refugee-oriented NGOs. The External Evaluator from IBHI (an influential Pakistani with international experience) had two meetings with the Federal and Provincial Health Secretaries along with the Managing Director of a d c Austria, Gert Kellermann, by way of introducing the new NGO as a resource for rural health care. Almost immediately both Health Secretaries announced their retirement; there was no follow-up. FPHC representatives later (1995) met with the new Provincial Health Secretary who expressed interest and requested more information, readily provided more than once. But nothing happened.

¹⁶ “If the health project does not change, it is in danger of becoming an island” he said to MMP and JSP, referring to the more effective provision by ARC/PHC to its target population at that time of 30,000 refugees.

2) In 1996, two senior staff (one expatriate, one Pakistani) of the Family Health Project (FHP) in Peshawar advised FPHC to submit a proposal, FPHC to offer itself in return for some financial support as an example of effective basic health care in keeping with the aims of the FHP, willing to work with GOP. A meeting between FHP and FPHC took place, a proposal was submitted. Nothing happened; the two senior FHP staff left for other jobs.

A change in attitudes: GOP as donor; and an in-country donor

GOP as donor

GOP's Draft National Health Policy document, planning for 1989-1999, while conceding that many indigenous NGOs are "*bogus*", says that the potential role of NGOs must not be underestimated (1989: 89). A seminar organised by GOP's Planning and Development Department (P and D Dept.) in 1994 on the topics of public health and water and sanitation attracted a wide range of participants. The document records considerable interest in community involvement in health and co-operation with NGOs, including transfer of GOP BHUs to NGO management (Seminar Report 1994: 27). So in spite of Key's criticisms, there did exist a climate of interest in change and possible partnership.

This P and D Dept. seminar was in anticipation of the Participatory Development Programme of the Social Action Project of the Government of Pakistan (SAP/PDP Phase 1). SAP/PDP represented an effort by GOP to address the chronic deficiencies in the sectors of Education, Water and Basic Sanitation, Health, and Family Planning. Funding for the two years 1996-1997 was channelled through the World Bank, reflecting increased international pressure around this time for NGOs to become more involved in development. In promoting SAP/PDP, GOP adopted a new role, that of donor willing to engage with the NGO sector. Hopefully, the successful NGOs would not be limited to Key's "Insider" category. FPHC was one of the 14 successful applicants across Pakistan, three of these being in NWFP.^{17 18}

An in-country donor: Trust for Voluntary Organisations (TVO)

TVO is an indigenous grant-making organisation created under the Special Development Fund agreement between GOP and the United States in 1988, which became operational in 1992. Based in Islamabad, TVO's aim is to provide grants and technical assistance to development-oriented NGOs for improving quality of life in backward and remote areas (TVO Annual Report 1995-6: 2-3). Its initial policy was to establish partnerships with large

¹⁷ The civil servant to whom FPHC representatives delivered the FPHC application reported surprise in his Department

(Planning and Development) at having received 119 applications from NGOs: about 30-35 had been expected. (MMP Journal)
¹⁸ Another successful applicant was Pak-CDP, the former Sanitation and Basic Health Project of ARC, an independent NGO since 1992.

and mid-level NGOs, such as the Family Planning Association of Pakistan (FPAP) in the expectation of a trickle-down effect which would benefit grass-roots organisations. By 1995, experience had promoted a policy change within TVO to supporting local NGOs. What these NGOs (or CBOs) actually do is not always clear from their names e.g. "Such-and-such Welfare Society"; "So-and-so's Community Development Association". The 1995-1996 TVO Report mentions only four NGOs receiving grants in NWFP, out of a total of 74 throughout Pakistan. Of these four, only one is obviously health-related i.e. Pak-CDP which specialises in water and sanitation, and includes some health education. According to the 1999-2000 TVO Report (pp 50-61) the number of NWFP NGOs funded had risen to 14, eight being health-oriented, but FPHC was the only one listed as providing Primary Health Care. Nabarro's comment (1994:4) that the "package" approach of PHC is not often implemented appears borne out by the TVO Report.

NGOs and donors: "Projectitis"

The relationship between donors and NGOs is crucial, for NGOs need income and as Key comments, in developing countries their dependence on external funding creates an experience for them which is fundamentally different from that of NGOs in western countries (1990: 41). Donors may be international bodies like UNHCR or UNICEF, or INGOs such as Oxfam or SCF. External donors (like implementers) may start from a value stance having little in common with the non-western cultures of the countries in which they are active, and in the case of health as Godfrey points out, their policies may derive from techno-biased medical systems not necessarily appropriate nor feasible. But just as INGOs are viewed as direct and speedy implementers, so are they appreciated as donors in allocating money directly to recipient CYNGOs, bypassing government departments.

"Projectitis" as it affects NGOs

However I am here concerned with the phenomenon of "projectitis" which can create problems for recipient NGOs. The term emerged from a DfID/BOND workshop in Edinburgh in 1997. At its most straightforward, it means the pre-occupation of donors with requiring applications for funding to be project-specific. That is to say, an applicant will usually have to tender according to guidelines drafted by the donor in accordance with the donor's policy. The donor expects precise descriptions of intended activity, outcome and beneficiaries, related to start and finish dates—anything between six months to three years. Sometimes an application may be intended to kick-start an NGO from scratch, and so "project" and implementing organisation are synonymous. If interests of donor and new

initiative are reasonably congruent there may be no significant problem. But for continuing organisations (which a new "project" may evolve into once its start-up phase is over), the situation is different.

Sustainability

An established NGO often has problems of sustainability (as in Korten's "third generation" strategy). Donors may be reluctant to contribute to its core funds, whereas an additional project within an NGO's work programme inevitably means extra administration. This reluctance may be partly to ensure financial accountability, but donors are often more interested in new initiatives than in maintenance. There is a danger that a donor may become so close to a project managed within an established organisation that it loses sight of the whole picture of the NGO's activities. For instance, the representative of the Netherlands INGO funding ARC's cross-border Rural Development Programme in Afghanistan visiting Peshawar in 1993 believed this was all that ARC did, and did not know of the existence of the PHC project (MMP Journal).

Differing priorities

An established and demonstrably competent NGO will have plans of its own which are legitimate and in keeping with its objectives, but which do not coincide with the prospective donor's priorities. Consequently the applicant, in the competitive funding market, has to be very ingenious in drafting a proposal to at least satisfy, if not exactly to conform to donor requirements.

FPHC needed ingenuity when submitting an application in 1995 to SAP/PDP Phase 1. The stated intention of the Austrian government to phase out funding to FPHC over two years made the application urgent. FPHC as a legal entity registered in Pakistan had existed only since January 1995, although its history as a health project went back to 1980. Credibility depended on evidence of long-term practical experience and financial management capacity, but that experience was largely with Afghans and within the Refugee Health Programme. FPHC's continuing commitment to Afghans had already rendered it unacceptable to several prospective donors. As a service-delivery organisation with resources both human and material, FPHC was ready and able to expand its service in an area of need—rural Pakistani nationals. The project-focussed nature of the SAP/PDP 1 scheme resulted in a draft proposal by FPHC to create a new Health Centre additional to the three already in existence, and in response to local demand. Describing the Health Centre as a new project was in essence a device to enable continuation of work in progress, expansion being part of the policy of

FPHC in its new identity. The SAP/PDP assessors took an enlightened view of FPHC and recognised its potential.

Poverty and continuing needs

In the health field particularly, relatively short-term funding characteristic of "projectitis" does not pay sufficient attention to the fact that people will always need health care, and that maintaining a service to the poor will never be feasible solely through their financial contributions, even supposing they are willing—and able—to make some payment. SAP/PDP Phase 1's lack of understanding and apparent addiction to "projectitis" stimulated a letter from FPHC to the Multi-Donor Support Group of SAP/PDP at the World Bank in Islamabad, which had oversight of the Participatory Development Programme. (MMP/FPHC/correspondence). Later, in June 1998, a representative of the Multi-Donor Support Group addressing the meeting in Peshawar University already referred to conceded that Phase 2 of SAP/PDP would take account of sustainability. In the end this pledge had no effect because Phase 2 failed to start.

Administrative complexity

Apart from the ingenuity required to tailor applications to satisfy a prospective donor, "projectitis" has other side-effects. When an NGO receives funds from several sources (it being prudent not to have all one's eggs in the same basket), reporting to the various donors becomes a complex and time-consuming task, many different styles of accounting, reporting and dates of submission being stipulated. This is especially so if each award is precisely focussed on a project or programme, or even part of a programme, or a locality. It is complicated for the NGO to administer and report on such a financial mosaic.

Projectitis and donors: change—or manipulation?

There is another aspect to projectitis. As there are fashions in aid and development work as in anything else, donor policies can alter, so that the donor seems to be promoting its own version of projectitis:

Policy change

Sometimes after the closing date of application for funding, or at least after informal discussions have led the NGO to understand that a submission will be welcome, things can change. The NGO may discover that unexpected requirements are to be attached to an award, seriously affecting the NGO's policy or planning. For example, FPHC applied to CIDA for funding another Health Centre (in addition to the one mentioned above) to extend

its service to more Pakistani villagers, according to policy. Suddenly CIDA announced that it would not fund service-delivery and would make an award only for staff and volunteer training purposes—"capacity-building", to include gender training. At what level this policy change was made is not known—possibly not within CIDA's Pakistan office, but at source in Canada. FPHC did find ways to accommodate the amended CIDA policy, and eventually to obtain funding for the planned additional Health Centre from another donor.

Conditionality

A vivid example of conditionality which appears to amount to a kind of projectitis is provided by Vaux (2001: 119-136) writing about Oxfam's failed water installation project in Kabul, the Afghanistan capital. After the Taliban took power in 1996, they imposed peace within the city and sufficiently throughout Afghanistan to allow some NGOs to become active in reconstruction. There has been widespread international criticism of the costs of this peace, which imposed severe restrictions on women and girls, who were not allowed to work or attend educational institutions, or indeed to be out and about at all, unless escorted by a male family member, and shrouded in the all-enveloping *burqa*. Oxfam had recently adopted a gender equality policy applicable not only within Oxfam itself but to its projects. The Kabul water scheme was therefore to go ahead only if the Taliban agreed to women participating in implementation from the beginning. Oxfam's expectation was that water was of such fundamental importance that agreement would be forthcoming. It was not. The Taliban viewed the seclusion of women as a priority, and the water scheme did not start.

Vaux admits that other factors probably also contributed to Oxfam's decision not to proceed with the scheme, but the incident illustrates the problems of a conditional or confrontational approach resulting from an inappropriate pre-occupation. Possibly if Oxfam had been pragmatic and introduced the scheme without insisting on women's involvement from the start, the Taliban might in time have relaxed their attitude sufficiently to let it happen, even if unofficially. As things turned out, Oxfam's policy, intended to be inclusive, helped to perpetuate the discriminatory practices of the Taliban.

NGOs and discrimination

By target group

Organisations such as Oxfam and the Red Cross make clear statements in their publicity that their policies are non-discriminatory. But policies are operationalised via on-the-ground implementation, often project-based, or confined to a particular location, or aimed at a specific target group. While this may seem commonsensical, in the interests of efficient management and finance, and no organisation can be all things to all men, anomalies can arise which may have a discriminatory effect. FPHC during its period of transition 1993-1995 from serving only Afghan refugees to its new identity serving also local Pakistanis without discrimination found itself caught between several stools. Prospective donors responded either by saying

"Our money is for refugees, and you are serving Pakistani people"

or

"Our money is for Pakistanis, and you are serving Afghans"

or even

"Our money is for Afghans in Afghanistan, not for Afghans in Pakistan" (MMP Journal).

These donors failed to appreciate the over-arching humanitarian motive of FPHC and its pioneering declared policy of non-discrimination. By contrast, two visiting senior officials from UNDP and the World Food Programme took a broader view and made no distinction in allocating cooking oil for distribution via FPHC—*"they are all residents of NWFP"* (i.e. both Afghans and Pakistanis)¹⁹. Neither organisation however could make monetary donations.

By location

Sometimes physical boundaries can have a discriminatory effect—SCF decided to close its office in NWFP, though working elsewhere in Pakistan, and could not help FPHC. FPHC may be said to have practised some discrimination itself: the Programme Officer (Health) of the Afghan Refugee Health Programme approached FPHC in 1995 to undertake basic health care (or at least EPI) in Koga, another camp which the Programme found difficult to serve. FPHC declined to help, on grounds that Koga lay outside its geographical target area.

Discrimination arising from reluctance to work in remote areas is encountered in the voluntary sector (noted above by Key) just as it is a serious problem for government services in Pakistan and other countries. The Deputy Project Director Health (DPDH) of the Afghan

¹⁹ This was part of a joint UNDP/WFP exercise to determine whether issuing cooking oil would induce improved attendance for antenatal care. FPHC was chosen as the participating NGO because of its reputation for accurate record-keeping (MMP Journal).

Refugee Health Programme told me that he had several times been approached by NGOs wishing to work with refugees, but they tended to stipulate a location within reasonable reach of Peshawar. As the Programme had no serious difficulties in servicing this locality, he turned down these offers. The need was in more distant camps.

Positive discrimination—or problem discrimination?

On the other hand, discrimination can work in favour of refugees. In the early stages of the influx, they were perceived as highly disadvantaged poor people, but UNHCR's prioritising of safe water and sanitation and electricity, using NGOs as partners for such installations provided a more uniform standard of basic amenities than in Pakistani villages, as mentioned above. If there are local difficulties in camps such as a high or low water table, it is the Commissionerate's responsibility to tackle this. As implementers of this kind of work, delegated by the Commissionerate, NGOs might appear to be significant contributors to this sort of discrimination, which can provoke friction between refugees and the local population, as happened in Bangladesh (Wijnroks 1993: 62). Godfrey's summation of the Afghan Refugee Health Programme and later comments to me by groups and individuals during field work in 2001 and 2002 illustrate the positive discriminatory effect of the joint UNHCR/NGO partnership.

Discriminatory effects of lack of central bank of information

As the body with oversight of the Refugee Health Programme, UNHCR lists its partner NGOs, but GOP Health Departments did not have official knowledge of health NGOs. The lack of any central body in Pakistan with responsibility to provide comprehensive and up-to-date information to GOP (or to any interested enquirer) about NGOs implies that there are resources which are underused and come to light only when a scheme like SAP/PDP 1 advertises for applicants. This lack has a discriminatory effect. There may be informal ways of getting round it, but they can be a matter of chance. When I interviewed her in April 2001, the Health Minister told me that she had heard of FPHC *"through mutual friends"*. Her interest in FPHC, and that of her successor, may develop further, hopefully with positive effects for the health care of some of the population of NWFP. But there could be other health-oriented NGOs working in NWFP (even in remote areas) unknown to the Health Department. They, like FPHC, may be able to demonstrate their potential to contribute to health care, in ways the GOP service could both support and benefit from.²⁰

²⁰ In 1996 two consultants from Mothercare/John Snow International) reported very positively on a small clinic in Skardu, Baltistan run by the Maternal and Child Welfare Association of Pakistan (Miller and Kelly 1996: 18-20).

NGOs: the problem of survival

For the health project of ARC in its transition to the fledgling NGO FPHC finding new donors became a problem of survival. Eventually donors were found, but for FPHC as for most NGOs, ensuring continued income is an ongoing process. After 1992, as stated above, many NGOs working with refugees withdrew from Pakistan; by 2000 the number of NGOs still active in such work was ten (personal communication from Director FPHC 24.04.03). After the official closure of ARC in 1994, the health project survived, but not without struggle, requiring change not only in identity but also in target population and work-style. Most NGOs had chosen withdrawal rather than adaptation.

An exception to the widespread NGO exodus was SCF (UK) which somewhat later, in 2000, approached FPHC for advice on how to manage transition to CYNGO identity as FPHC had done. This concern arose out of SCF's decision to withdraw from its refugee-focussed health project in Haripur. It was reluctant to see the work disappear and was searching for ways to enable the activity to continue. Some discussion took place with FPHC, but the events of 9/11 in New York and its consequences, including the need to cater for a new influx of refugees, put an abrupt stop to any contemplated change by SCF. It is interesting that it is another NGO rather than GOP which saw the FPHC precedent as a feasible route to retaining a resource.

Conclusion

The range of NGO activity in Western countries is much wider and more sophisticated than in Pakistan. World War II and globalisation however have stimulated financial and practical involvement by Western countries in the developing world, including Pakistan, via UN bodies and international NGOs. Early relief orientation shifted towards development.

Pakistan's history as a politically closed society featuring militarism and patronage limits its ability to provide universal basic health care to its people and has not encouraged a dynamic voluntary sector. The indigenous NGO sector has general problems affecting the sub-set of health-oriented NGOs, such as confusing out-of-date legislation and lack of a central information and monitoring body. Information about CYNGOs is therefore inaccurate and incomplete; many appear to exist on paper only. Some NGOs with close links with the elite tend to follow a traditional charitable model. These deficiencies are coupled with inertia on the part of GOP, which has paid little attention to NGOs. A few large INGOs and CYNGOs

tend to dominate the Pakistan scene, some acting as donors to other organisations as well as managing projects of their own. NGOs tend to be urban-based: few are located in NWFP.

Some CYNGOs may operate along more professionalised lines and may be locally effective providers of health care like FPHC, but lack political influence. Their activity may be a disincentive to GOP to improve its service. In the 1990s GOP showed more interest in CYNGOs by seeking their involvement in basic services via SAP/PDP Phase I, but Phase II failed to start. The in-country donor TVO recently became more supportive of local and grassroots NGOs. Active NGOs appear to have increased in numbers in recent years, but generally their involvement in health care is small-scale and piecemeal.

By making separate living and health care arrangements for Afghan refugees, the UNHCR/GOP partnership created a parallel health care system. GOP has used researchers both indigenous and expatriate to address problems in its own basic service, who have explored to some extent the potential of NGOs as contributors to GOP's health system. These research exercises (i.e. post-Godfrey) within NWFP have not examined the Refugee Health Programme as a whole nor the NGOs working within it. The Programme is widely perceived by the refugees, by local people and by some professionals as preferable to, and more effective than GOP service. Apart from some functional cross-over arrangements between the two services, GOP appeared to take no interest in assessing it or the NGOs working in it as a potential resource. Researchers have been denied (or failed to notice) the opportunity to discover how and why these positive perceptions have come about. Their findings might have been (or could still be) relevant for the development of GOP's own service.

As a project of a refugee-oriented INGO which has transformed itself into an independent CYNGO, FPHC survived (unlike most other NGOs working in refugee health) by changing not only its formal identity but by extending its boundaries, adopting an inclusive policy, and in effect, creating a bridge between the two discrete basic health care systems in NWFP. It has been ingenious in combating the "projectitis" which can distort declared NGO policies. In addressing the danger of isolation from the wider community it has had to create a new set of donor relationships, including with GOP, though by year 2000 perhaps not a secure one.

In terms of Korten's generational strategies, FPHC has moved beyond the first stage of "Relief and Welfare", and since 1995 has become much more involved in second generation "Community Development", while remaining a service-delivery primary health care NGO. Movement towards the third generation of "Sustainable Systems Development" is subject to institutional, policy and financial constraints because of the way that GOP and other

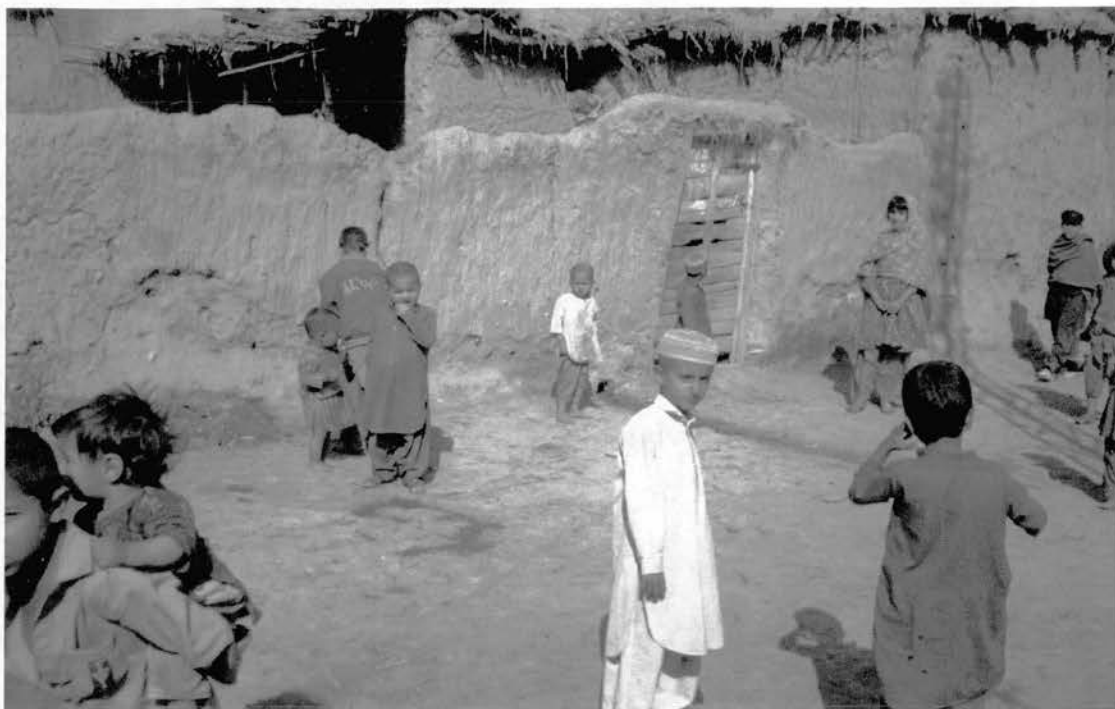
agencies work, including donors. However, FPHC conforms to Key's classification of "Entrepreneurial" NGOs, which he suggests have potential for greater influence and recognition by government. FPHC's ability to survive for over twenty years and its adaptability suggest an optimistic rather than a pessimistic view.

As FPHC seems to be the only CYNGO in NWFP claiming to provide Primary Health Care (and recorded by TVO as doing so), the next three chapters will examine the validity of FPHC's claim, according to principles underlying the Declaration of Alma Ata: participation, inter-sectoral collaboration and equity. The first of these (Chapter 6) will consider community participation, which links with Korten's second generation of "Community Development".

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Inside a refugee camp



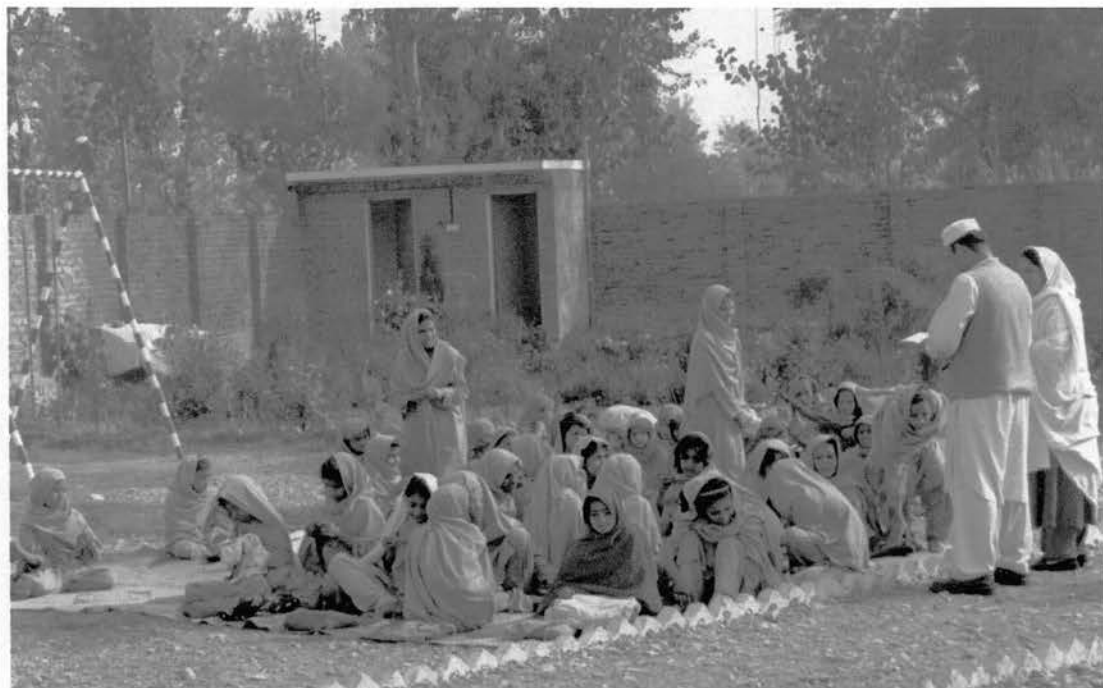
Inside a Pakistani village



Gandaf camp Health Centre (men are staff). The building at the back right is the MCH unit.



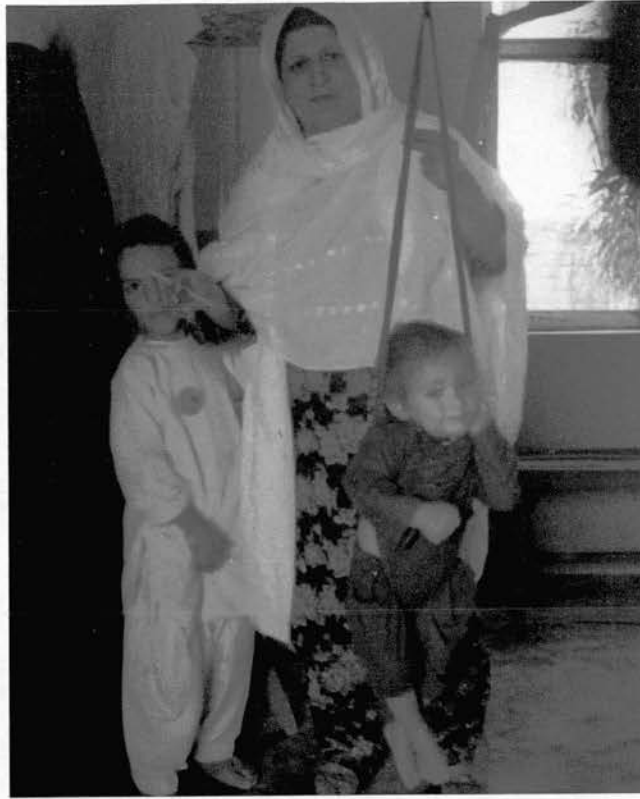
Wardaga village Health Centre – women and children only



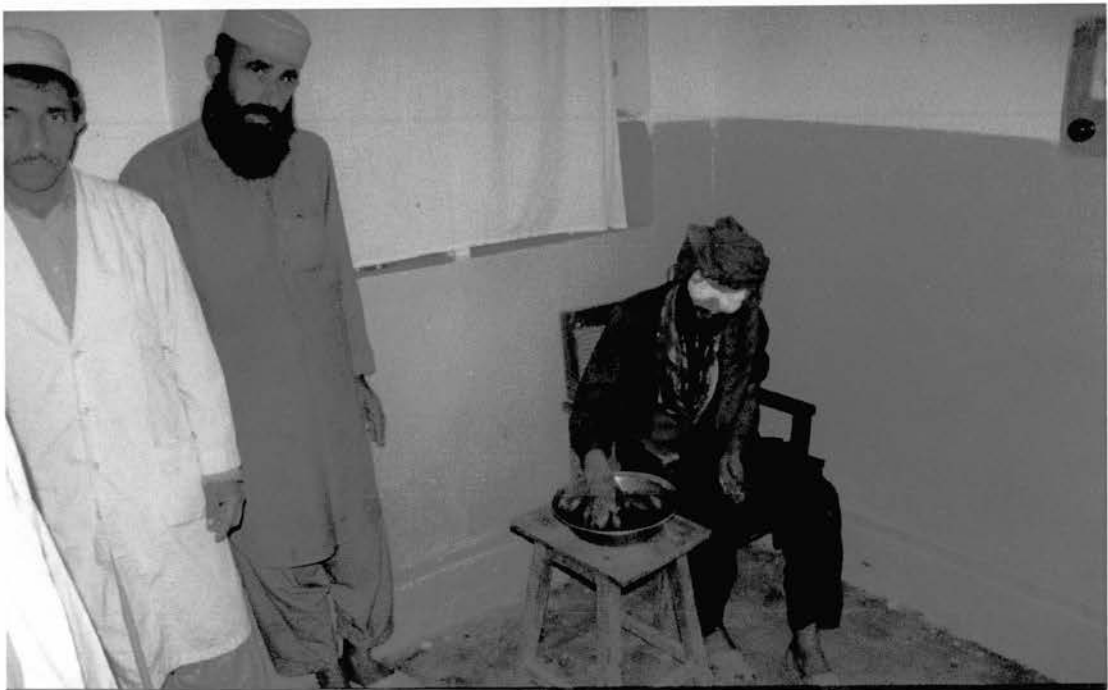
Girls' class at Baghicha camp, held outdoors during winter. Latrine in background.



Girls growing into women



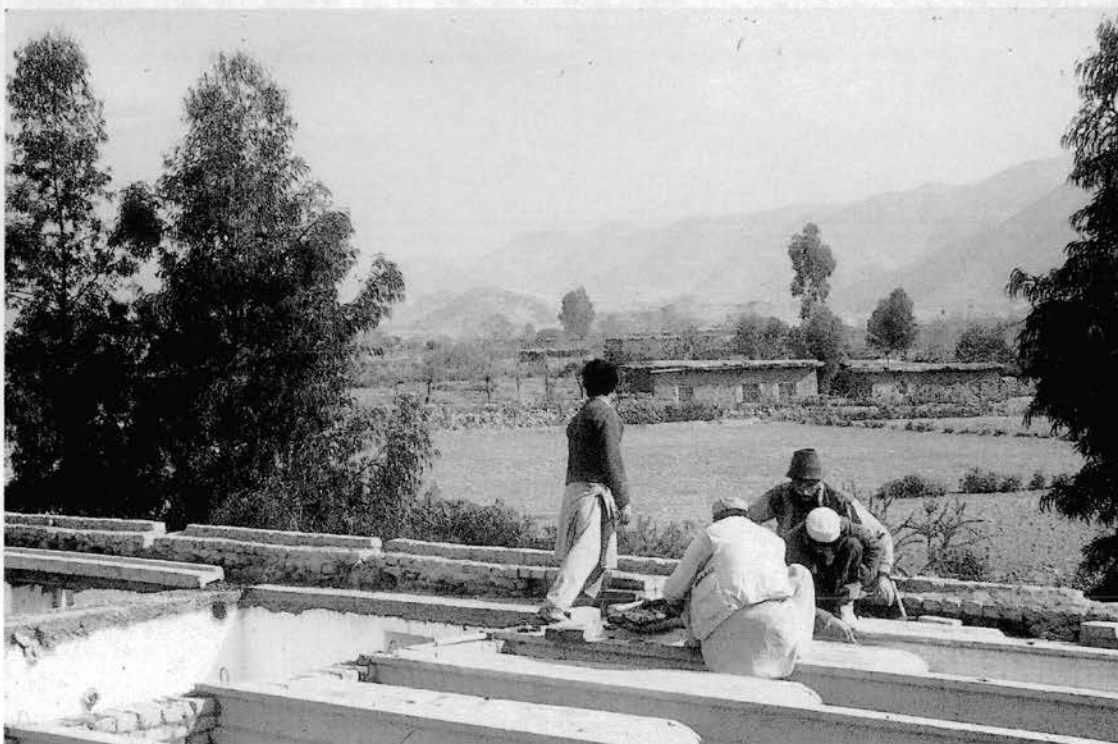
Lady Health Visitor monitoring child weight.



Back from Afghanistan—treating a mine injury



Treating children in a tent during repairs to Gandaf camp Health Centre.



Camp residents repairing roof at Gandaf camp Health Centre

CHAPTER 6

THREE PILLARS OF PRIMARY HEALTH CARE

THE FIRST PILLAR: PARTICIPATION

Speaking as a senior doctor associated with the Afghan Refugee Health Programme since 1982, Col. Dr. Altaf ur Rahman Khan stated at interview in May 2002 that the "Three Pillars" of PHC were curative, preventative and health promotive. These words recur in the Annual Reports of ARC/PHC from 1983 onwards, summarising the policy—the official rhetoric—almost slogan—of its health work. These terms, curative, preventative and health promotive, might be regarded as headings for grouping or classifying the eight components as in Table 6.1 below:

Table 6.1 PHC components by group

Curative	Preventative	Health Promotive
Treatment of common diseases and injuries	Immunisation	Health education
Provision of essential drugs	Control of endemic diseases	Mother and child health including family planning
	Safe water and sanitation	Adequate nutrition

Article VII of the Declaration of Alma Ata declares these eight components the minimum for inclusion in PHC as a strategy for "Health for All" by the year 2000. Most are medical tools to be employed in furtherance of the strategy, but the Declaration also refers to other constituents of PHC as follows (*italics mine*):

Article IV: *The people have the right and duty to participate individually and collectively in the planning and implementation of their health care*

Article VII(4): *PHC involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the co-ordinated efforts of all those sectors*

Article VI: *PHC is essential health care based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.*

The Three Pillars

Macdonald (1998) identifies these concepts of community involvement, co-ordination of sectors and universal provision as underlying principles or "Three Pillars" of the Declaration: a broader interpretation than that offered by Col. Altaf. Macdonald calls them participation, inter-sectoral collaboration and equity, and declares them fundamental to the holistic nature of PHC strategy. Health personnel trained along traditional curative lines, he says, are inclined towards feasibility and practicalities of implementation of PHC, supporting a more selective version. It is possible for medical professionals to implement the eight components of PHC, but without addressing the "Three Pillars", this will not be true PHC (Macdonald 1998:77). He asserts that this medicalisation without considering the "Three Pillars" does not address the underlying problems of poverty and political problems which seriously affect the health of whole populations. Implicit in the concepts of participation, inter-sectoral collaboration and equity is a challenge to the *status quo* not only of the way health care is provided but also of the way human, economic and material resources are managed in society. Unless the "Three Pillars" are tackled, he warns, the strategy falls short of the intended impact on—indeed revolution in—health care across the globe.

This chapter examines in more detail what is meant by participation, the first of these three ideological concepts of PHC. The two following chapters will consider inter-sectoral collaboration and equity.

Implementing participation: an additional consideration—leadership

There is a body of literature on participation—perhaps the most written-about of the "Three Pillars". Eyben however, referring to other recent critiques of the requirement to participate argues that total participation in a project, i.e. by every member of the community would be very time-consuming and impractical (1995: 197). She argues also that participation can go too far, especially when some specialised or expert knowledge is required, as in the case of health. The Alma Ata Declaration itself does not reject techno-medical procedures. Expert professional knowledge therefore has a place in PHC: for health and health care,

participation by the community is not enough. Nor according to Macdonald's warning can PHC be handed over to medical professionals who are likely to adopt a mechanistic or selective approach. The inference is that implementing PHC will require respect and support for community participation, together with professional expertise and an ability to judge when techno-medical procedures are appropriate. In dismissing the assumption that effective basic health care requires new and expensive technology, Caldwell says

"instead it depends on density of service; on efficiency of service (whether self-induced or caused by the client's insistence) often under a physician's leadership" (1986: 2000)

The literature on PHC seems to pay only occasional attention to the question of leadership. The Declaration of Alma Ata does not consider the role of leadership in PHC nor the relationship between leader and community participation. Accepting Eyben's argument as valid, this chapter, in assessing how far participation features in health care practice at the NGO FPHC, includes some discussion of leadership and its significance for FPHC.

Three Services

The chapter focuses on FPHC, active in the three NWFP Administrative Districts of Mardan, Swabi and Charsadda. It also refers to the two other basic health services in NWFP:

1. the joint UNHCR/GOP Afghan Refugee Health Programme via its system of BHUs in camps in NWFP¹
2. GOP's service to its own nationals, via its BHUs in the same three Administrative Districts as above

Common features

What these three systems (FPHC, the Refugee Health Programme and GOP) have in common is that they are first points of contact for their target populations; they share the status of "primary care" in the sense of first level of care.² Where they differ is in the range, style and content of care they provide, as reflected in the variation in numbers and responsibilities of the typical staff complement at each BHU or Health Centre, as in Table 6.2.

¹As explained in Chapter 2, restrictions and the abrupt end to my 2002 fieldwork aborted visits to Refugee Health Programme BHUs in matching Districts. I was able to visit only one (Shamsatoo) in District Kohat.

² Private practitioners may also be first points of contact for those seeking health care—particularly people able to afford it—but private practice is outside the scope of this case study.

Table 6.2 Staff complement at field units of 3 services

FPHC Health Centre	Ref. Health Prog. BHU	GOP BHU
Team leader (M or F Dr.)	1 M.O. (Medical Officer–male)	1 M.O. (male)
1 Pharmacist/Compounder	1 Lady Doctor	1 Male Medical Technician
1 Registrar/Clerk	1 Dispenser	1 Female Medical Technician
1 LHV	1 LHV	1 EPI Technician
1 MCH Assistant	1 Vaccinator	1 LHV
1 Lab. Technician	1 MCH Assistant	1 <i>Dai</i> /TBA
1 Nurse Asst./Malaria Supervisor	1 Male CH Supervisor	1 Ward Orderly
1 Dental Assistant	1 Female " "	1-3 <i>Chowkidars</i>
2 vaccinators	1 Health Educator	No Driver
1 or 2 CH Supervisors	1 Driver	No volunteer CHWS
1 or 2 <i>Dais</i>	1 <i>Chowkidar</i>	
1 Driver	Male and Female volunteer	
2 <i>Chowkidars</i>	CHWs	
M and F volunteer CHWs	All BHUs have a Lady Doctor; labour rooms with 24-hr. peripatetic Lady Doctor service are located at some BHUs, to serve several; lab. services are similarly selectively located.	
Total minimum paid staff is 15; but at Wardaga HC (MCH-F/P) small female team only		

Sources: FPHC data from Annual Reports; Refugee Programme data from MO at Shamsatoo BHU; GOP data from MO at GOP BHU, Swabi District

Note: During their visit in September 1995, the SAP/PDP Assessors advised FPHC to change the name of its field units from BHUs to "Health Centres"—*"because you offer more than GOP BHUs."* (MMP Journal).

Another feature shared by the three systems is that at field service delivery level, they all operate as doctor-led teams. Godfrey as noted in Chapter 5 traces the decision to use doctors in the Refugee Health Programme to pressure on GOP in previous years by the Pakistan Medical Association. Chapter 3 explained that the doctor-led team was established in the early 1980s. In response to WHO advice to move the Programme towards PHC, SCF introduced training for Community Health Workers (CHWs), building on needs expressed by the community itself. Ajmal's paper (1988: 3-4) states that the doctor-led teams, after fixed stations had been set up, realised they could not cope without help, and CHWs represented a means of getting it. The Refugee Health Programme adopted this structure of doctor-led teams supported by trained volunteers, as did partner NGOs providing health care in the camps, including ARC/PHC.

Comparing the services

Chapter 4 described the slow progress towards "Health for All by the Year 2000", and the variability of attempts at PHC by governments of various countries. The same chapter demonstrated the inability of GOP to provide a reliable first-level service in spite of in-country expertise and repeated legislation. This chapter and the two following are concerned less with the failure of government than with seeking evidence of understanding

and implementation of the fundamental principles or "Three Pillars" of PHC as a health strategy. That there happen to be three different systems of basic care operating within one province of Pakistan, NWFP, suggests that some comparison of their understanding of the "Three Pillars" is possible, as evidenced in their work-style and leadership.

To do this, these chapters use data collected empirically over the years 1991-1998 and during two fieldwork visits. Chapter 2 explained reasons for discrepancies in data concerning GOP and Refugee Health Programme services. Detailed comparison has therefore not been possible, nor is it possible to relate data from the GOP system or the UNHCR/GOP Refugee Health Programme to FPHC's five-year developmental phases. Nevertheless, the phases retain some usefulness for analysis, and references to the Refugee Health Programme and GOP's system provide some background to FPHC's operations. This is because the three agencies functioned contemporaneously if separately over the twenty years 1980-2000, and all aimed to provide basic health care to similar target populations—rural poor people in NWFP.

The first pillar: participation

Defining community participation: the Afghan refugees

According to the Declaration of Alma Ata, participation means involvement by people, individually and collectively, from the community. The literature on community participation shows that neither word is as simple as it may appear. Community is not a monolithic concept: no community can be homogenous, containing as it will people of many different ages, interests, political affiliations and social or socio-economic groupings. Membership may change over time, as in the case of the prolonged existence of Afghan refugee camps in Pakistan.

Chapter 3 demonstrated that the Pakistani government, while apparently welcoming the Afghans at the time of the major influx in the early 1980s, saw them as distinct from Pakistanis (even if they were, like most inhabitants of NWFP, Pukhtuns or Pathans) requiring special arrangements for accommodation and health care. The initial segregation may have been a matter of practicalities, in the expectation of a fairly short stay by the Afghans in Pakistan, but the policy established them as an officially separate "refugee" category, still enduring after twenty years. They do not constitute a homogenous community. In addition to the diversifying characteristics noted above, there were successive waves of refugees, some mostly rural people after the Soviet invasion, some more sophisticated from Kabul in 1992, others in 1999 because of several years of drought in Afghanistan, others still

later after the events following 9/11 in New York, which triggered American military activity in Afghanistan.

How these people were perceived within Pakistan changed over time. In 1994, in Peshawar, the European Commission's Co-ordinator for Refugees hinted to me in conversation that "*economic migrants*" might be a more appropriate term for long-stay refugees: public transport in Peshawar is mostly in the hands of Afghans. From time to time the press has reported incidents of violence involving refugees, particularly in Karachi (MMP Journal; Kukreja 2003: 147, 248, 307). While compiling the External Evaluation of ARC in 1993/4, Zia Rizvi could obtain no clear statement from any of his contacts with GOP officials of any definite policy on the status of the refugees (conversation with MMP/JSP 1994). In March 2001, when I interviewed the Commissioner for Afghan Refugees (NWFP), a GOP appointee³ and himself a Pathan, he declared several times that the refugees were "*foreigners*". Yet the border between Pakistan and Afghanistan remains a dotted line on the map—the Durand Line, a British administrative device dating from the 1890s. It is recognised as porous both by Afghans and by Pakistanis, in spite of Pakistan's reported attempts to close it after the events of 9/11.⁴ At the time of Zia Rizvi's enquiries in 1993, senior politicians and officials admitted informally to him that they thought some refugees had been so long in Pakistan that they would never go back to Afghanistan. UNHCR staff in Islamabad said much the same to me in interviews and informal conversations much later, in April 2001.

These general observations about Afghans in Pakistan apply to the three ARC/FPHC camps of Kagan, Baghicha and Gandaf:

"It is unlikely that the majority of Afghans in the camps covered by the PHC project will return home voluntarily in the near future, if at all"

"The majority of the population of the three camps was born and brought up in Pakistan" (External Evaluation Report 1993/4: 44-45)

The three camps have existed since 1980, and the population appeared settled. ARC/PHC/FPHC's system since 1992 of monitoring movement in/out of the three camps using family registration cards confirmed that the annual turnover was small—about 4% (field notes 2001). These camps contain people with many different tribal and sub-tribal allegiances,⁵ and each camp has individual characteristics. For example, Gandaf, the camp

³ He was the eighteenth holder of the post; all but two of his predecessors had lasted only a few months.

⁴ The Commissioner stated that the border was in fact officially closed in November 2000, i.e. almost a year before 9/11/2001, in an attempt to prevent any more "drought" refugees entering Pakistan.

⁵ One of my responsibilities as Administrator at ARC/PHC 1991-1993 was to authorise small inducement payments to *Dais* if they brought women to the clinics for three ante-natal check-ups. Some *Dais* appeared to be more effective than others, thus being entitled to more cash. Staff told me that this was a matter of sub-tribal affiliation rather than recognition of any individual's expertise.

furthest from Mardan, seems more isolated, and conservative attitudes are more prevalent among the residents (see para below on "social groups"). On the other hand, Kagan camp is the nearest to Mardan Town, and is literally across the road from Kagan village, whose residents were the first non-refugees to attend Kagan camp Health Centre in substantial numbers. But there is more similar than there is different within this long-stay three-camp group: they are all Pushtu speakers originally from the eastern provinces of Afghanistan⁶, with a shared identity of refugees, Pathans and Sunni Muslims, and all registered patients of FPHC. It is reasonable therefore to apply to them the definition of "community" quoted by Rifkin, Muller and Bichmann (1988: 933) as the one most often used in health literature:

"Community is a group of people living in the same defined area sharing the same basic values and organisation".

This is a rather wide definition, but it suits the population of the three camps: not only do they live in the same defined area, and come from the same part of Afghanistan, but they came at the same time—early 1980, as was stressed by the three veteran FPHC staff members interviewed in March 2001. That health care for the people in these two, later three camps was provided from a single source, ARC, was probably also a bonding agent: senior staff (especially Dr. Zamani) were peripatetic and highly visible, and multiple trainings enabling flexibility of staff rendered them familiar at all three BHUs. Until 1995, ARC provided help in kind to these camp residents, such as soap and suits of clothing for mothers and newborns. The three veterans emphasised shared religious conviction as influencing the refugees' gradual acceptance of the new kind of health care being imposed on them:

"the brotherhood of Islam means that you have to help other people, and they understood that this was for the betterment of the people".

The non-refugee community

Refugee camps, created by GOP and recognised by their residents and by local Pakistanis as such, constitute more clearly defined areas than Pakistani villages, though day-to-day movement of Afghans in and out of the camps is not restricted. Local Pakistanis do however identify closely with their own villages, even if their work has required them to move away and live somewhere else (MMP Journal). Villages have their own individual characteristics—FPHC senior staff perceived Wardaga village as more socially stratified than Ismaila village. Baghicha village women complained that *"there are no khans (landowners) in this village"*, meaning that according to cultural norms *khans* would have assumed responsibility for help with community problems such as water supply (interview 2001). These villagers accepted

⁶ Logar, Kunar and Nangarhar

the idea of traditional leadership and had expectations of it. Like the camps, the villages had more in common with each other than they were different. Each was a community in itself, but together they constituted a social group distinct from the camps, and the definition by Rifkin et al. appears valid for them also.⁷

Analysing community participation

Rifkin criticises inadequate analysis of community participation, saying that it is really a multi-layered and controversial concept (1985, quoted by Tatar 1996:1494-5). There are later and perhaps more sophisticated analyses of community participation, one of which I refer to later in the chapter. However, as an analysis constructed and published during the formative years of ARC/PHC, still quoted after the transition to FPHC in 1995, Rifkin's is a suitable framework for assessing how far community participation is a feature of the NGO. It is also possible to make some links between the other agencies and Rifkin's framework. Fieldwork interviews and conversations produced evidence about understanding of PHC as a health strategy, as well as about participation and the other two ideological "Pillars".

Rifkin identifies five discrete stages or levels of community participation in a health care programme, but she considers that attaining the higher levels (4 and 5 below) is rare.

According to Rifkin's framework, people can participate:

1. as passive recipients
2. by taking part in the activities
3. by implementing the programme
4. by being involved in monitoring and evaluation
5. by being involved in planning the programme

The process of applying this analytical framework to an organisation is not totally straightforward. Allocating an individual feature of organisational behaviour to any one of these levels of participation may be problematic. FPHC has passed through various phases, some reactive to external pressures, others more planned, sometimes pragmatic in the interests of survival. Allocation of a particular organisational feature in this analysis may be criticised as fudged or idiosyncratic; but human behaviour (and language) is capable of many different interpretations simultaneously. The analytical process requires decisive choice.

⁷ Some Afghans have found places to live in the villages, but they are not Pakistani citizens

The following analysis of data is based on Rifkin's framework. It concentrates on FPHC material, mostly according to the five-year phases; data from the other services is incorporated to provide a context, as far as this is possible.

Participation analysis

1. The first level of participation—"passive recipients of service"

Overall, fieldwork evidence was that people from the target groups of each of the three services did attend the relevant facility, as shown in Table 6.3 below. The figures show patient attendances on the days immediately before my visits, obtained from records, unless otherwise stated

Table 6.3 Numbers of patients attending on one day

GOP BHU	Nos.	Target Pop.	Ref. Prog. BHU	Nos.	Target Pop.	FPHC HC	Nos.	Target Pop.
Mardan	33	16500	Shamsattoo	40 -45	10000	Baghicha	55	10000
Swabi	75	19500				Gandaf	58	15000
Charsadda (a)	50	12000				Wardaga	21	4500
Charsadda (b)	15	16000						
Charsadda (a) and (b) figures are estimates by MMP on days of visits. At a visit to Charsadda (a) in 1998, there were no patients			Estimated daily average according to MO			Wardaga HC concentrates on MCH; target pop. is approx. 75% of total village sub-area 6000 pop. = 4500		

While attendance is likely to vary by season, day of the week and other random factors, these observed and reported differences in attendance figures (from nil in 1998 to 75 in 2002) between the GOP BHUs visited, together with comments by patients and staff, are indicative of low expectations of that service. That attendance partly depended on the availability of medicines (according to patients) suggests that patients and staff perceived the service as curative-oriented. The buildings I saw needed repair; low morale of staff and patients at one GOP BHU suggested that both groups were there because there was no realistic alternative for either employment or health care (see chapter 5). Two GOP BHUs (not visited) were reported as non-functioning.

The chief exception to the negative picture of the GOP service was the BHU in Swabi District, which had the largest attendance figures, including some patients from *khan* families. Leadership by a long-serving and committed MO was probably the reason for positive comments from patients. Contrasting visits (1998 and 2001) to a Charsadda District BHU also illustrated the positive effect on patient attendance of a new vigorous MO. Staff at the single Refugee Programme BHU I visited said that availability of medicines affected patient attendance. Some staff arrived late and I saw others including staff from other BHUs in the camp leaving together by minibus early on that day.

Charges to patients did not seem to inhibit attendance at any Health Centre or BHU (GOP charge was Rs 1 or Rs 2) and there was no evidence of treatment being refused because of inability to pay.

“Passive recipients” at ARC/PHC/FPHC by phases

All FPHC patient groups made positive comments about FPHC’s service, mentioning its dependability, the availability of medicines and (women especially) antenatal care. Supplies were less at risk at FPHC which managed its own budget and purchasing.

1980-1984

The original mobile teams providing medical relief were an attempt to impose order on chaos. Stringent limitation of women’s movement (staff as well as patients) affected attendance. It was not acceptable for male staff to attend women. Men could bring children (and still do) but some adult patients would have been prevented by existing health problems or handicap.

1985-1989

Under Dr. Zamani’s leadership, deliberate efforts were made to build trust and encourage patients to attend. Fixed stations helped to increase attendance, but

“The External Evaluation Team found that health programmes have taken 5-6 years to capture the target (refugee) population as a whole. The main difficulty has been to reach the women: a satisfactory female attendance of 80-85% was not attained until 1989” (External Evaluation Report 1993/4: 33).

1990-1994

The history chapter explained the pro-active and influential behaviour of Kagan villagers opting for ARC/PHC’s service. Between two and four thousand villagers attended the Kagan BHU, but service to them was restricted to OPD curative work, so as not to prejudice work

for the refugees. No special records were kept of these attendances (ARC/PHC Annual Reports 1990: 2, 1993: 8)

1995-2000

At FPHC Health Centres a typical recorded attendance was in the mid-to high 50s (total male and female), as the table above shows , except at the fairly new Wardaga Health Centre (MCH only: 21 patients). Although patients (refugee and non-refugee) commonly said that “everyone” used the Health Centres and BHUs, some female patients (both refugee and non-refugee) said that some husbands were reluctant to let wives attend. Informants thought these were few. No service could provide numbers of non-attenders, but this reluctance appeared more applicable to peripheral or newer Health Centres. A long-stay refugee woman at Baghicha camp commented on FPHC: “*we can speak openly here; this is our own hospital*” with which the rest of the interview group agreed (the refugees commonly refer to FPHC Health Centres as “hospitals”). This suggests close identification with FPHC, even a feeling of ownership.

Neither refugee nor non-refugee groups thought the charge (Rs 10) per head per Health Centre visit excessive. Although it was sometimes necessary to borrow, they considered the range of services good value for money; they had to borrow less than if they used private practitioners. Baghicha village women said that they and their men-folk disliked having to wait at the Health Centre; some of their men therefore used private practitioners. The same group considered the Children’s Park too far away for their children to use.

According to the MOs at two GOP BHUs, about 20-30 Afghan refugees per month attended, in addition to the target population of Pakistani villagers, but no disaggregated figures were kept. These were non-camp refugees living in local villages. Acceptance of these people for health care agrees with the understanding that refugees could use GOP BHUs. I saw a few Afghan women waiting at FPHC’s Wardaga village Health Centre; these were not camp women, but village residents. The MO at the Refugee Programme BHU said that no Pakistani people attended his BHU, which is sited far distant from any local villages in a rocky barren part of District Kohat.

2. The second level of participation—“taking part in activities”

GOP

If Health Committees qualify as “activities”, there was little evidence of their existence in the GOP system, and little enthusiasm for them by middle-management. Comments by the

three Executive District Officers (Health) (EDOs—all doctors)—who had all attended courses on PHC—on lack of understanding by Health Committees and on the prevailing community bias towards pills and injections suggested that they had yet to consider seriously the concept of participation. One EDO had instructed his MOs to set up Health Committees at each BHU; he himself had tackled health education and breast-feeding via public meetings, but it is not clear whether women attended. Women patients at the Swabi BHU said there was a Health Committee whose members were teachers or from *khan* families, but they were unclear about its activities.

ARC/PHC:

1980-1984

My notes on the ARC Annual Report of 1981 mention “camp committees” without detailing what they did, but as at this date ARC was chiefly engaged in health work, presumably they were concerned at least partly with health matters.

1985-1994

The Annual Reports do not record any activity by camp Health Committees during this period, nor did we (MMP and JSP) know of the existence of any during our 1991-1993 VSO commitment. From 1985 onwards ARC/PHC under Dr. Zamani’s leadership focussed on developing a service and building training, until he had to leave in late 1991.

1995-2000

FPHC’s planned extension into the villages stimulated an increase in “taking part in activities”. In the villages as in the camps, the active community body is the *jirga*, a male Pathan local assembly. The *jirgas* set up health committees, and at Gandaf Health Centre 2 (village) there was in addition a younger men’s committee (“Gandaf Young Welfare Society”) which undertook physical activity (e.g. drainage maintenance) at the request of the *jirga* (FPHC Annual Report 1998: 5)

In the camps Health Committees (men only) discussed problems such as water supply (e.g. high or low water table related to incidents of flooding or drought) for referral to the Commissionerate for Afghan Refugees. Male patients could approach the Health Committees about individual problems, which were passed to staff and fed upwards through the reporting system and/or the Project Council.⁸ Women had no direct access to the Health

⁸ This body consisted of 17 staff members, some *ex officio* (e.g. Team Leaders) and some elected by staff. In 1996 it included 6 women (Annual Report: 6). In 2000, the balance was 21 men, 8 women. As an advisory body with no executive responsibility, meeting quarterly, it was a forum for discussion (Annual Report: 6). No meeting was scheduled during my visits.

Committees; they had to be represented by a male relative, but the usual route for women was through female volunteer workers and female staff.

At FPHC second-level participatory activities other than health committees started in this latest phase. Most were initiated by Dr. Emel Khan, Director FPHC, and his wife Dr. Wagma Reshteen following a conscious decision to become more community-oriented, but there is at least one instance of FPHC attracting voluntary practical effort by villagers i.e. building a shelter for waiting patients (see Health Minister's observations below). During group interviews, male/female attitudes towards new opportunities for participation were rather inconsistent: the bias applies to villagers as well as to refugees and is culture-based.

By year 2000, the following participatory activities were under way:

- **Construction work:** FPHC's policy (inherited from ARC) was to pay labour (refugees and local people) for maintenance and repair of Health Centre buildings and Children's Park premises⁹. Work in the camps such as rubbish collection and cleaning of drains remained voluntary and unpaid. Camp residents made all equipment (swings, slides etc.) at the children's play parks, using money donated for the purpose from St. Johann School in the Austrian Tyrol to buy materials. At Ismaila village where a former GOP BHU building was transferred to FPHC to use as a Health Centre, local people assured the Health Minister when she made an unannounced visit that they were building a waiting-shelter for patients of their own volition, and that they would not have done this for the Government BHU (interview with Health Minister 5.3.01).¹⁰
- **Breast-feeding groups** in camps and villages (staff training provided by The Asia Foundation (TAF)) gave women a chance to meet and talk on other subjects as well, e.g. children, general health matters and education. One young woman in the Wardaga patient group said she was a good cook and felt she could share her knowledge in a group. Men raised no objection to these groups. By December 2000, there were 50 of these groups distributed as follows:

Kagan camp and village	10
Wardaga village	14
Baghicha camp and village	12
Ismaila village	4
Gandaf camp	6
Gandaf village	4 ¹¹

⁹ Rates of pay are Rs 70-100 per day for labourers, Rs 150-200 for masons and Rs 120-180 for painters (personal communication from Director FPHC 22.7.03).

¹⁰ The Minister said she had noticed on this occasion that about 60 patients were present at the FPHC facility, whereas she had seen about ten waiting at the GOP BHU she had just left.

¹¹ Personal communication from Director FPHC 13.01.04

Management obtained some unexpected benefit in the form of information from women's groups. For instance, LHV's used a check list during home visits to verify that women had received ferrous sulphate tablets, but in group discussions some women were able to say that they were not actually taking them.

- **Health education groups for men** in camps and villages were set up (meeting roughly monthly) as a decentralised method of disseminating information previously broadcast (literally, via BBC Pushtu tapes) to patients waiting at the Health Centres; the groups began to discuss family planning and sexually transmitted diseases (STDs). Informed discussion of these subjects among male patients was a new venture; management recognised that progress would be slow.
- **Patient contributions:** All ARC/PHC programmes were free to camp residents until 1994. During the third phase 1990-1994 issues of rations to refugees in NWFP from UNHCR/WFP gradually ceased, but ARC/PHC continued to distribute soap, made-up clothing for new mothers and babies, and lengths of cloth or plastic sandals to volunteer health workers annually, as inducements and to combat poverty. In the 1995-2000 expansion phase, FPHC discontinued all hand-outs in accordance with the new declared policy of non-discrimination. Following discussions with Dr. Emel Khan and other FPHC staff, elders in camps and villages agreed to the introduction of a patient financial contribution of Rs 5 for each visit to a HC. Programmes themselves were free. By 2000, the charge had been raised to Rs 10. Charging for the service appears to have altered the relationship between community and organisation. It represented a movement away from the dependency/handout model, as did opportunities for group discussion and free exchange of information between patients and staff. However unrealistic the "charge" of Rs 10 in terms of costs of the service, it suggests a concept of patients' (or customers') rights.
- **Premises for training:** In the 1995-2000 phase, FPHC ceased training middle-grade health workers and closed the Mardan Residential Training Centre. It relied on local people to provide rooms on a temporary basis in camps and villages, so that training of volunteers could be peripatetic and in the community. Some Community Based Organisations (CBOs, e.g. one at Madey Baba, Mardan District, and another in Punjab, the Col. Sher Mohammed Welfare Society) sought training from FPHC for CHWS and TBAs, and volunteered local temporary training accommodation (FPHC Annual Report 1999: 32).

- **"Social groups":** FPHC tried to start another kind of forum: "social groups" for women. These were intended to stimulate interest in education and training, but progress was slow. According to senior staff, women were reluctant to maintain membership, unless there was some inducement—cash or free equipment e.g. sewing-machines, for which FPHC had no funds. At Gandaf HC 1 (refugees only) one member of the staff group said that *"the camp women cannot run groups, because they are illiterate"*. This staff group was all-male, apart from two Pakistani LHVs, new employees, who came in late but stayed behind to tell me that they believed the women *were* able to run groups. Male patient groups at Gandaf camp and Baghicha village said that there was no need for women's groups: *"it is against our traditions, and the women think the same"*. Female patient groups did not support this view: Baghicha refugee women knew there were such groups in the camp, but their particular men-folk did not permit them to attend.¹² Baghicha village women also expressed interest in groups. Gandaf refugee women were in no doubt that they would like groups; one older woman was emphatic that she would be willing to take on responsibility, and that she would like to help women to obtain work in order to combat poverty.

There was no evidence of activities comparable to those described above at either GOP or Refugee Programme BHUs. The "special instance" of participation described below is peculiar to FPHC's status as an NGO.

A special instance of participation at FPHC

FPHC as an NGO has a local Board of Governors. Firm management and accumulated staff experience of the health project meant that over the years it came to function virtually independently of the ARC's Vienna Board and of the Peshawar Office. In 1994, in anticipation of life as a Pakistan registered NGO, the health project was required by legislation to have a management committee. The aim was to recruit high-profile influential people with community links. Nine Pathans local to NWFP, six men and three women, agreed to become members of the Board of Governors of FPHC. They comprised several doctors, a lawyer, a banker, a local industrialist, and three people with a background in education. FPHC was very pleased to secure as first Chairman of the Board Khan Abdul Ali Khan¹³.

This rather back-to-front arrangement of a committee being superimposed on an organisation functioning semi-independently for 14-15 years is unusual. In the voluntary sector, the

¹² This interview group turned out to be members of one family—grandmother, daughters-in-law, granddaughters; prohibition on group involvement may have been peculiar to this family.

¹³ Deceased 1996

pattern is for a group of interested activists to found an NGO. After it has become established and is able to employ paid staff, at least some of the originators remain as committee members in the role of policy- and decision-makers. Participation by FPHC's Board of Governors needed education rather than being taken for granted, given that the PHC ideology was new to virtually all of them. As middle-class people using private health care (some were private medical practitioners) their bias was towards curative medicine. After their first group visit to a FPHC Health Centre, they expressed disbelief that what they saw—a large number of patients and all staff busy—was daily normality; they supposed that the scenario had been specially set up for them.

"One of the handicaps of FPHC has been an inability to constitute a dynamic, active and effective Board of Governors—they give no press interviews and are not involved in fund-raising campaigns" (External Evaluation Report 1998: 7)

They are all indigenous Pathans who expressed interest in joining the Board, but as middle-class people they have different community links from those of refugees and villagers. Nevertheless all meetings of the Board achieved a quorum, and by year 2000, membership having changed slightly, understanding seemed to be growing. As no Board of Governors' meeting was scheduled during fieldwork trips, I did not interview this group, but it was reported that Governors had shown more interest in visiting Health Centres, had made small donations and started to bring their own files to meetings. But by year 2000 they had not facilitated a route to any source of substantial finance from within NWFP, as had been hoped. On the other hand, they showed no sign of dominating.

3. The third level of participation—"implementing the programme"

This is an example of possible fudging: is the use of volunteers "taking part in activities" or is it "implementing the programme"? On balance, I have opted for allocating it to implementation, on the grounds that trained volunteer workers recruited from the community are integral to health care as practised at FPHC and the Refugee Health Programme. It was intended to be of practical use in health care, and as such it continued to be a striking feature of the Refugee Health Programme, distinguishing it from GOP's own service. Training for Programme volunteers in year 2000 was provided via the specialist Training Unit, part of the Peshawar Office of Project Director (Health) of the Refugee Health Programme, but it is not clear whether training activity was conducted in Peshawar or de-centralised to camps. Each volunteer was reportedly responsible for approximately 30 houses in their neighbourhood.

GOP BHUs visited produced almost no evidence of community involvement in service implementation. Staff at one BHU said they had trained some local practising TBAs in

hygienic methods, but there were no arrangements for supervision or contact after training. Staff at another GOP BHU had recently attended a course on PHC, and knew that TBAs were active among their target population, it being traditional for Pathan women to be delivered at home. But there was no official connection between the BHU and these women. None of the EDOs (Health) expressed an interest in volunteer workers or awareness of their potential in implementation, though all had attended courses on PHC.

The exception was the GOP Swabi BHU, where effective leadership had found some ways of compensating for shortcomings and frustrations of the system. The MO had started training for local TBAs. Their status is more that of independent practitioner than volunteer, since they expect families to pay them, but the MO allowed them access to the BHU “clean room” for deliveries. He had set up this facility on his own initiative. When I visited, the LHV post at this BHU was vacant, but Lady Health Workers (LHWs of the Prime Minister's Scheme) were reported to help with some deliveries—not an official part of their duties. No GOP BHU (nor FPHC) has a labour room of the type provided by the Refugee Health Programme listed in Table 6.2.

Volunteers at ARC/PHC/FPHC Health Centres

Dr. Zamani used the training then available via the Refugee Health Programme to introduce volunteer workers during the **1980-1984 phase**. At first he trained Community Health Workers (CHWs), 34 men only, (ARC Annual Report 1984:12) following SCF guidelines. CHWs were equipped with basic kits, but no medicines, and acted as first referral points in their immediate neighbourhoods. They were trained in basic hygiene, to do simple dressings, to recognise symptoms and when to advise attendance at a Health Centre. Gradually Dr. Zamani began training TBAs, 30 in 1985 (AR 1985 :24). In the **second phase 1985-1990**, he trained some workers to become trainers themselves—one was in 2000 a Master Trainer in FPHC's Human Resource Unit. During the 1980s many more workers were trained, in preparation for the expected return to Afghanistan. In the **fourth phase 1995-2000**, Dr. Emel Khan's streamlining exercise weeded out the inactive surplus and trained more villagers. FPHC expanded training for women (TBAs) to include health education, and changed their name to Female Health Workers (FHWs) (see table 6.4 for job descriptions of CHWs and FHWs). FPHC's Annual Report of 1996 records 368 CHWs/FHWs active in the community (FPHC AR 1996: 6). By 2000 the volunteer establishment was 1 CHW and 1 FHW for every 100 houses in camps and villages (Annual Report 2000: 30).

Figure 6.1 Job Descriptions for CHW and FHWs

FRONTIER PRIMARY HEALTH CARE



ROLE OF VOLUNTEER COMMUNITY HEALTH WORKER (MALE)

- Responsible to:** Team Leader of Health Centre through CHS
- Who is he:** He is a member of community who has received training in health education, first aid, referral of patients to health centre/hospital, detection of cases of TB, Malaria; detection of defaulters of immunisation, TB, Malaria etc.
- His selection for training as Community Health Worker is based on the following criteria:
- Literate man who can read and write
 - A man who has his own job but can be available in community
 - Acceptable to community
 - Willing to work as volunteers
- Role:**
- He must have knowledge of his target area and population
 - Encouraging people for involvement/participation in health care programmes.
 - Sharing information with community on prevention and control of common diseases; mother and child health (antenatal, natal and postnatal care); personal and environmental hygiene; importance of EPI, use of safe drinking water and use of latrines.
 - Sharing information with community on importance of family planning and where necessary make proper referrals to appropriate facility for family planning services
 - Provision of first aid facility to community
 - Helping families for promotion of breast-feeding
 - Detecting of cases of TB, Malaria, Hepatitis etc. and reporting them to the health centre

continued on next page

- 8) Helping health centre staff in detection of defaulters of EPI, TB, Malaria etc.
- 9) Participation in different campaigns e.g Polio eradication, sanitation, crash programmes for immunisation, control of Malaria etc
- 10) Helping people to develop health eating habits (Nutrition)
- 11) Where necessary to become member of health committee
- 12) Attending monthly meetings of CHWs and submission of monthly report of activities
- 13) Attending refresher course and monthly workshops for CHWs.

Qualification:**Formal:**

- 1) Some literate (can read and write)
- 2) Training as Community Health Worker

See over also

FRONTIER PRIMARY HEALTH CARE



ROLE OF VOLUNTEER FEMALE HEALTH WORKER

Responsible to: Team Leader of Health Centre through LHV

Who is she: She is a member of community who has received training in maternal care, safe birthing practices and child care. Her selection for training as Female Health Worker is based on the following criteria:

- a) Active woman
- b) Mobile woman (allowed by her family to go to houses in her community and local health centre)
- c) Married
- d) Acceptable to community
- e) Committed to learn and share information for bringing positive change in community

Role:

- 1) Ensuring that all women and newborn babies/infants in her target area are immunised
- 2) Helping pregnant women to have better nutrition and care for their health (ensuring proper antenatal care)
- 3) Early recognition of risk factors for mother/ baby during pregnancy/labour and where necessary, making timely referral to appropriate health facility.
- 4) Providing care at home after delivery.
- 5) Sharing information on importance of family planning and making proper referral of clients for family planning services
- 6) Helping families in promotion of breast-feeding practices.
- 7) Giving advice on common ailments and referrals to HC

Qualification:

Formal:

- 1) None but preference is given to woman having primary level qualification
- 2) Training as Female Health Worker

Source: obtained from FPHC Office, Mardan, April 2001

The 1993/4 External Evaluation noted (p 320):

"At present some 75% of the total employees (of the health project) have worked themselves up into the staff from previous positions as volunteer CHWs in particular. Consequently they know the work involved from the bottom up."

This suggests a reinforcement of the third level of participation, in that some people (mainly men, but some women too) could through on-the-spot skills training as middle-grade health workers such as laboratory technicians, malaria supervisors, vaccinators or trainers become even more closely involved with health care, while still remaining members of camp communities. However, in year 2000, volunteering did not seem to be generally perceived as a route to employment within FPHC. Loss of trained volunteers may occur, paid employment, even if it is elsewhere, being a priority for poor people; volunteer health workers are unpaid. Originally, it was the camp population—the defined community—which was the sole source of volunteers. If volunteers demonstrated capability to graduate to staff level after further appropriate training, this seemed to be an instance of helping Afghans to help themselves, in accordance with ARC policy.

4. The fourth level of participation—"monitoring and evaluation"

No arrangements for formal monitoring or evaluation appeared to exist at GOP BHUs, but group interviews revealed that patients were able to voice evaluative comments and suggestions for improvements—at least to an external interviewer—about shortages, rudeness and unpunctuality of staff, and the need for a Lady Doctor at the BHU. There is nothing new about this: it confirms findings from Lafond and White in their 1993 case study of NWFP, referred to in Chapter 4. Exceptionally, again at the Swabi BHU, patient behaviour—high attendance numbers—and comments by patients about the MO, the service, and training for staff, showed a positive perception of that BHU, but no formal arrangements existed for evaluation.

There was no indication that any arrangements existed for Refugee Health Programme patients to monitor or evaluate the service, but Refugee Health Programme BHU teams were better staffed (see Table 6.2) and had the reputation of being better equipped and more effective than GOP's service. Doctors with Refugee Health Programme experience were reputed to be better doctors than GOP BHU doctors, as mentioned in chapter 5.

Monitoring and evaluation at FPHC Health Centres

ARC/PHC/FPHC's formal mechanisms for monitoring and evaluation via its reporting systems, regular meetings (including the Project Council) and supervisory structures were

designed for staff rather than patients. When we arrived in 1991, we found all of these in operation, evidently part of an established system. Male CHWs were supervised by each team's Community Health Supervisor (CHS, a staff member) and female HWs by LHV's and through the Team Lady Doctor by Dr. Wagma, who managed the MCH programme. All volunteers had regular monthly meetings with relevant staff teams. Each team submitted monthly quantitative data to the FPHC Office in Mardan for analysis. This amounts to recording the volume of work; the Evaluations of 1998 (p.10) and 2000 (Summary) comment on FPHC's under-use of routine data for self-evaluation, planning, and re-definition of organisational objectives in terms of output and effectiveness.

In the **third phase 1990-1994**, it was practice to hold an annual staff party in Mardan, when various awards were presented—certificates to trainees, best employee etc. In 1992 JSP introduced a visual presentation of annual statistics, highlighting differences between the three camps. Initially this produced a somewhat defensive response, but staff began to understand that this was a way of assessing work and moving it forward, just as the Project Council enabled discussion based on day-to-day work and contact with patients and the wider community. The Annual Staff Party regularly thereafter included a formal presentation intended for staff to make criticisms and suggestions. While this may be interpreted as good management practice rather than community monitoring and evaluation, it was an attempt to get staff to look at work more objectively than as a means of winning approval from seniors. In my opinion, these processes of reporting and assessment might be said to constitute community participation in monitoring and evaluation. This is on the grounds that at that time almost all staff and their families were Afghans belonging to the distinct and limited population of three camps, responsible for the health care of the community of 30,000 refugees; they were themselves refugees and patients.

This opinion cannot be sustained beyond 1995 when FPHC was formed. By year 2000 two-thirds of the total FPHC target population of 100,000 (including the original Afghan group) were Pakistani villagers, this total being a more diffuse group. Many additional volunteers were villagers; they participated in the monthly meetings with paid staff, but as new quasi-staff they were perhaps insufficiently distanced from the organisation to be critical. Some exploration is needed of arrangements for direct monitoring by patients from this more numerous and widespread target population comprising Pakistanis as well as Afghans.

In fact, by year 2000, FPHC had not created any formal mechanism for direct monitoring and evaluation by the community. Fieldwork evidence was of a generally positive perception of FPHC, but senior staff reported that some patients were able to communicate

criticism either individually or as a group to management—and to expect explanation and/or action. They volunteered the following anecdotal evidence of monitoring by patients:

- A refugee mother complained that she had been told that her baby's stool specimen was clear of infection. She told the Team Lady Doctor that she thought the lab. technician was not doing his job properly—*"because I know my baby is not well—there is blood in his stool"*. A second test showed an infection was present.
- A male patient wrote to the FPHC Office to complain that the Health Centre Dental Assistant was directing patients to a private practitioner, which the writer knew was contrary to FPHC policy.
- A recently appointed FPHC doctor with a background in mental health was spending so much time with individual patients that the waiting queue complained that they feared they would not be seen that day—and they had paid their Rs 10.

These actions take confidence (and in the case of the letter-writer, a certain educational level)—patients' own self-confidence and confidence in the service, that is, that action will follow if they make their voices heard. The last example illustrates the "patients' rights" concept linked with the introduction of the patient contribution. Dr. Emel Khan said he saw complaints as evidence of a positive relationship between patients and the organisation.

Dr. Shabina's Evaluation of FPHC in year 2000 did address community evaluation in her use of patient "exit interviews". This however was external, and there was no continuing formal mechanism for patients to participate in monitoring and evaluation. In her Evaluation Dr. Shabina recommends as a step towards this level of participation the use of a trained participant evaluation specialist:

"participatory evaluation by the project participants on a regular basis would be beneficial, being an interactive process" (2000: 13)

5. Evidence of the fifth level of participation—"planning the programme"

The lack of evidence of any community participation in monitoring and evaluation or in planning in either the Refugee Health Programme or the GOP system supports Rifkin's comment that participation at the fourth and fifth levels is rare. At ARC/PHC/FPHC planning has a history, illustrating the importance of styles of leadership in the project's different phases.

1980-1984

There is no evidence of planning by the community in the earliest years, but there is no doubt that Dr. Zamani's identity as an Afghan refugee was of prime importance. A member of the refugee community, though never a camp resident, he was planner, implementer and exacting monitor. In his interview he said being an Afghan "*probably helped*". As an Afghan *khan*, his authoritarian leadership commanded traditional loyalty. It was effective in creating order, and later in moving from curative to preventive work—indeed he imposed it. A former employee of ARC/PHC/FPHC (himself a Pakistani doctor, interviewed 27.0.01) said he thought no expatriate could have done what Dr. Zamani did—"*well, perhaps a Pakistani Pathan, but no, not an expatriate*", an opinion supported by the long-serving ARC/PHC/FPHC Administrator. Dr. Zamani also appreciated the need for evaluation: the Chairman's Report incorporated in the ARC 1985 Annual Report (p 2) records the insistence by the then Director of ARC together with Dr. Zamani on external evaluation, though neither envisaged evaluation by the community.

1985-1989

The behaviour of local villagers in starting to attend Kagan camp BHU of their own accord does not constitute planning, but it is a statement of preference based on experience. Although they received a limited service, they created a relationship which influenced later development.

1990-1994

Gandaf Health Centre 2 (village only) was set up by FPHC on lines similar to existing Health Centres i.e. to provide a full range of programmes. This followed talks between the village *jirga* and the health project staff. The *jirga's* approach to FPHC was not so much an exercise in planning as a reaction to the contrast between the NGO's observed practice and the local GOP BHU, which seldom functioned.

1995-2000

There is evidence of real involvement in planning in this phase:

- In 1995 a small Community Based Organisation (CBO) in Dr. Emel Khan's home village, Wardaga, agitated for FPHC to set up a Health Centre. Wardaga is a large village spread over a wide area, officially with access to a GOP BHU in Charsadda District. A sub-area of Wardaga comprising about 6000 people was sufficiently distant from that BHU to make it difficult for women to attend, transport and male escort being obligatory. It was this population sub-group which pressurised FPHC.

- The Asia Foundation (TAF), a potential donor, became interested in FPHC as a health-oriented NGO suited to TAF's policy of promoting community participation (interview with senior TAF staff April 2001). TAF offered PRA training as a condition of a financial award for a health facility. In listing needs via PRA, Wardaga villagers included improved educational facilities, road repairs, employment and leisure provision, including a cricket ground,¹⁴ but opted for MCH and Family Planning as a health priority. Wardaga HC opened in 1997 in makeshift premises providing a service with this focus. Staff were female, with only one man as Registrar, responsible also for health education groups for local men¹⁵. FPHC gave basic training to local TBAs, with ongoing supervision by staff.

A by-product of this exercise was the transformation of the local CBO into a formally constituted NGO, the Wardaga Welfare Society, with a Women's Section. The new body became the referral point for any emerging community concern, health or other.

- At Ismaila village in 1997 where villagers had asked for a Health Centre, PRA elicited a slightly different set of priorities, viz. sanitation, general health provision, road repairs and job opportunities. This last may reflect criticism voiced by nearby Baghicha village women that local tobacco factories used labour from elsewhere, including refugees, in preference to local men.
- In 1999 a spontaneous request emerged from patients at Baghicha Health Centre, serving both refugees and villagers. They demanded pregnancy testing, obtainable at a price from the private sector. FPHC responded by making it available, charging a fee of Rs 10, in addition to the standard patient contribution of Rs 10.

Evidently since 1995 FPHC leadership had become open to participation beyond training of volunteers. This responsiveness and willingness of the leadership to adapt to other ways of working was not its only characteristic. However before moving from assessing participation at FPHC according to Rifkin's analysis, and to an exploration of leadership for primary health care, another model of analysis has some relevance to leadership at the NGO FPHC.

¹⁴ Wardaga women did not see this item as a priority.

¹⁵ Dr. Emel Khan could see male patients when he came home to Wardaga at weekends.

An alternative analysis of levels of participation offered at FPHC:

The chapter explained the reason for choosing Rifkin's analysis based on five levels of community participation. Dr. Wagma Reshteen, wife of Dr. Emel Khan, had worked with the health project since 1988 (as he did) and as senior Lady Doctor since 1995 managed MCH/Family Planning. She also led FPHC's Human Resource Development Unit. She volunteered that at a UNHCR workshop in Peshawar in year 2000, conducted by a member of SCF (UK) staff, she had learned that there are *six* levels of community participation. This was the second workshop on the topic Dr. Wagma had attended. In May 2002 she listed the following levels of participation:

- as passive receivers—acceptance of what is offered
- carrying out assignments given by management
- consultation re needs/problems e.g. needs assessment via PRA or surveys
- exchange of meaningful ideas—re programmes—or between community and those running the programmes
- involvement in planning process and in solutions
- taking responsibility for leadership—partial and even total responsibility

Dr. Wagma had felt able to relate this presentation of "levels" to her own experience at ARC/PHC/FPHC. She assessed FPHC's progress through the levels thus:

Level 1: as receivers—definitely.

Level 2: carrying out assignments—in various ways e.g. volunteer health workers; building maintenance; older girls and teachers marshalling children or helping with record-keeping at EPI sessions or polio days

Level 3: consultation—more at Wardaga and Ismaila, the newer Health Centres, where PRA was used

Level 4: exchange of ideas—to some extent—at Wardaga, where topics arose from PRA; groups met regularly and sent ideas to FPHC (not only on health); exchange of ideas more evident at Ismaila (I did not visit this newest HC) because of fewer social divisions; in some villages *khans* may resent intrusion by external agencies.

Level 5: planning and solutions—partially—at Wardaga; when a school had to be closed, the teacher adapted her room in her family compound, using it for a year to teach basic literacy. No salary was available; she ran two sessions daily for 60 girls, 30 in each. After initial reluctance, her family accepted this. But Dr. Wagma said there was no real planning by the community. She thought staff as community members should be better at providing ideas.

Level 6: leadership—partially—in Wardaga village some women are running groups and approach FPHC for help only when they want it.

Dr. Wagma considered that staff needed to be stimulated by management. She attributed their inhibition to a carry-over from relief-directed work—a combination of dependency and a top-down model of management. Younger people, women as well as men, she felt, were more likely to produce ideas, and educational level affected capacity for innovation.

There is some fudging between this 6-level model of participation and Rifkin's 5 levels e.g. where to locate individual items such as volunteer workers, or what qualifies as planning. For this case study, however, the interest in this analysis is less as an alternative to Rifkin's than that it was cited by Dr. Wagma who has a leadership role at FPHC. Her contribution demonstrates:

- understanding of theoretical aspects of participation
- continuation of learning and application to practice, based on long and intimate knowledge of organisation and community
- appreciation of opportunities and encouragement of community participation
- understanding that participation takes a long time

Dr. Wagma also demonstrated appreciation of basic PHC theory, offering the spontaneous opinion that

*"FPHC's practice is nearer to CPHC than to SPHC; what is missing is full responsibility for safe water and sanitation"*¹⁶

I believe it unlikely that I would have obtained comparable evidence of willingness to learn and of insight into theoretical aspects of PHC and participation, linked with practical

¹⁶ The Commissionerate is responsible for water installation and major repairs in all camps. FPHC teams monitor sanitation and arrange bulk purchase of materials for minor repairs done by camp residents. Village water and sanitation is highly variable: FPHC in 2000 was able only to give health education and to encourage shared use of water pumps from deep wells.

experience of its application, from any staff I met from the other two health care systems. These attributes have implications for the place of leadership in a PHC programme.

Leadership for primary health care (PHC): arguments for training

The Declaration of Alma Ata places the responsibility for PHC on governments. Vaughan and Walt, quoted by Tatar note

“After the Declaration the world experienced a boom in CHW projects, mainly because the PHC approach became synonymous with introducing CHW schemes, and these schemes were the easiest way of showing the commitment of the Ministries of Health to the PHC approach” (Tatar 1996:1495).

Pakistan’s Ministry of Health did not adopt this policy. Its small BHU teams lacked community involvement, authority was retained at the centre, thus generally inhibiting leadership potential at unit level.¹⁷ While the Refugee Health Programme added CHWs to doctor-led teams, the training for new MOs (mostly Pakistanis) joining the Programme instructed them in techniques appropriate to the components of PHC; it did not explain underlying ideology and the potential of community participation. That the identity of Project Director Health (PDH) changed eleven times in the twenty years of the Programme’s existence cannot favour either continuity or consistent development.¹⁸

This seems to fit with Macdonald’s comments at the beginning of this chapter stressing the probable constraints if management is in the hands of medical professionals. However though the Declaration does not mention the word “leadership”, it does note in Article VII (7) that health workers should be trained “*socially and technically*” to work as a health team and in Recommendation 15 calls for appropriate management training of health workers of different categories. It acknowledges that health professionals have a role as trainers.

Conversion and understanding is part of training for PHC leadership

Neither Dr. Emel Khan nor Dr. Wagma had any formal training in management when they joined ARC/PHC in 1988, Dr. Emel Khan as a Team Leader. They had both been conventionally trained, but their practice altered considerably. Dr. Emel and Dr. Wagma (and other FPHC staff) provided evidence that experience in a PHC setting can produce a

¹⁷ Local *khan* influence may have helped Swabi BHU to be an exception: it is unusual for an MO to be in the same post for seven years. Lafond and White note influence of politicians on siting of BHUs and recruitment and transfer of staff (1993: 360).

¹⁸ The PDH post is within the Refugee Health Programme, a joint UNHCR/GOP exercise, but the appointment is in GOP’s gift. A public health qualification is not a requirement. The post-holder in 2002 was previously a paediatrician. LaFond and White (1993: 55) point out that promotion in the GOP health service is dependent on seniority, not aptitude, specialist training or quality of work.

change in professional mind-set necessary for effective practice of PHC. Dr. Emel recalled his own (and others') resistance to the PHC approach when in the mid-1980s he worked as a BHU MO in the Afghan Refugee Health Programme in Baluchistan. But in 2001:

"I am a public health person. I was a typical doctor, but now I am a health worker" (Dr. Emel Khan)

"I was a medical college lecturer, now I am a health worker" (Dr. Wagma)¹⁹

A doctor joining FPHC will have been trained along traditional medical lines, and the public health approach of FPHC will be new to him. Some doctors become converts and committed members of staff. Dr. Wagma considered that not all doctors achieved this transition from the curative to the public health orientation. It usually took some time, but she thought the process could be accelerated via a 2-3 week induction course for new members of staff (not implemented at time of interview). Dr. Shabina recommended in her 2000 External Evaluation that some training in management would benefit Team Leaders (2000: 11).

If the Declaration's call for management training is one argument for the need for leadership in PHC, Eyben's reservations on the impractical and unrealistic nature of total participation when specialist knowledge is needed amount to a second. They are echoed by Stone (1992: 412) who alleges that the values of self-reliance and equality as promoted by advocates of participation (and mentioned in Recommendations 2 and 12 of Alma Ata Declaration) are not necessarily shared by some non-western cultures. Some community members may not be enthusiastic about participating or assuming responsibility, and look to traditional leaders, as did the Baghicha village women who wanted help from *khans*. On the other hand, some people may be only too eager to become dominant. Sometimes the community may prefer the professionals to make the decisions; external decision-making can help to reduce feuding.

Writers on PHC who recognise that community participation in itself is not enough include Rifkin, Muller and Bichmann. In constructing a framework for measuring participation they include leadership as one of six influential factors:

- Needs assessment
- Leadership
- Organisation
- Resource mobilisation
- Management
- Focus on the poor (1988: 933-939)

¹⁹ These comments contrast with the statement by the Afghan MO at Shamsatoo camp BHU, who said that his practice had not changed in the 20 years he had worked at several Programme BHUs: *"I am 20 years older, that's all"*.

It would be possible to discuss each of these in detail as it may be evident at FPHC, but here I am concerned only with leadership. Boerma is another writer on PHC Teams in developing countries who declares leadership to be an important factor in their functioning. Boerma however is not discussing government provision, but leadership in health-oriented NGOs:

"It has been suggested that the success of many small-scale PHC projects has been strongly associated with charismatic leadership in those projects. In particular, this pertains to projects of NGOs. The success of the Jamkhed experiment which was one of the projects that laid the foundation for the development for the PHC strategy has been ascribed to the special dedication and organisational capabilities of the team leaders" (1987: 747)

"Leading a voluntary organisation is a complex task and the social, political and economic uncertainty accompanying development makes the job even more difficult. Under these conditions successful leadership requires a realistic appraisal of the opportunities and limits presented by a given environment upon which to base organisational strategies...Most successful voluntary organisation leaders in developing countries are elite members prior to engaging in voluntary activities" (Key 1990: 17-18).

Both of these quotations imply a strong "personalising" element in leadership of NGOs, of which health-oriented NGOs are a sub-set. There is personal involvement between middle-management and service delivery team leaders, and between team and community, in which the team leader should be instrumental. To quote Dr. Wagma:

"There is freedom to work here, an open feeling. There is not only a doctor/patient relationship but a relationship with the community and a social relationship with the community as well" (April 2001)

The quotations from Boerma and Key also imply long-term involvement on the part of leaders. Bermejo and Bekui acknowledge the importance of such continuity:

"Participatory methods require personnel stability so as to gain understanding of community needs and to recognise the longer-term benefits of such programmes" (1993: 1147).

If it is accepted that total community participation is in itself neither practical, realistic nor sufficient for implementing the PHC strategy in developing countries, and that leadership is essential, then the PHC leader as well as having appropriate specialist knowledge and expertise is also likely to be charismatic, shrewd and realistic, provide continuity, and probably have an elitist background.

Leadership at ARC/PHC/FPHC

Enough has been said in this and earlier chapters to indicate that Dr. Zamani qualifies as a charismatic leader. Key's comment is relevant to the first, second, and part of the third phases of ARC's health project 1980-1984-1992. In making use of new learning and opportunities for change, Dr. Zamani appears to have demonstrated "*a realistic appraisal of the opportunities and limits*" in the "*given environment*" of disruption and dislocation as in the quotation from Key above. He already had personal authority deriving from his elite *khan* status; his shared refugee identity rendered him acceptable to camp residents. During his tenure, while volunteer workers provided some community participation, and many junior staff achieved the stability mentioned by Bermejo and Bekui, Dr. Zamani's continuing senior presence helped to offset rapid turnover of qualified professionals.

In spite of the distressing hiatus after Dr. Zamani's traumatic departure in 1991, when MMP's and JSP's presence provided some stability for the health project, continuity was eventually ensured by the promotion of Dr. Emel Khan. In 1992 he was appointed Acting Medical Co-ordinator, then Co-ordinator, with uninterrupted transition to Director of the new NGO in 1995. The FPHC Administrator believed that approachability was characteristic of the new leadership style, saying "*his(EK's) door is always open*". ARC/PHC/FPHC presented a number of challenges to Dr. Emel which he said he recognised as opportunities for organisational and personal development.²⁰

Dr. Wagma, who is Afghan by birth, but whose family has connections with Charsadda District, gradually assumed responsibility for MCH and Family Planning, and developed her teaching role. By year 2000, she was doing almost no clinical work but was leading the Human Resources Development Unit, in charge of all training. She understood her own gradual development from "teacher" status to "facilitator", using different methods with different groups of people. She believed that participatory methods encouraged contributions, leading to improved learning and staff confidence. She identified the 1995 movement into the villages as a watershed in her own development, when more training workshops had to be set up for staff and volunteers. She appreciated a TAF course on counselling as an impetus to her own learning.

In the twenty years 1980-2000 therefore, the health project had experienced only one change of leadership, but in the fourth phase, the leadership had become in practice a joint one, characterised by more delegation and de-centralisation, noted in Dr. Shabina's evaluation

²⁰In 1997 he attended a Health Services Management course at Cardiff University, arranged by JSP, funded by a d c Austria..

(2000:11). Greater approachability and flexibility derived from the personalities of the leaders. Staff remarked that

"Dr. Emal and Dr. Wagma are good listeners". (Wardaga staff team 2001).

A visiting VSO volunteer, a mental health nurse tutor, commented in 1992 on Dr. Emel's easy relationship with patients (MMP Journal)—an indication of his interpersonal skills, which have had to develop further as FPHC's external relationships increased. CIDA staff commented on the strength of Dr. Wagma's contribution to FPHC's development. The leadership characteristics of specialist knowledge, sensitivity to practicalities, organisational skills and elitist background were apparent in this husband-and-wife partnership of Dr. Emel and Dr. Wagma. Dr. Emel belongs to a local *khan* family and Dr. Wagma is the daughter of a former Vice-Principal of Kabul University.

Another significant continuing presence at ARC/PHC/FPHC was the local army-trained Pakistani Pathan who from being the health project Admin. Assistant in 1988 progressed through Administrative Officer to Administrator. It was he who was left in temporary charge of the health project when Dr. Zamani attended a three-month management course in The Netherlands July-September 1991. His efficiency, experience, industry and support were positive factors during the inevitable uncertainty after the trauma of late 1991. His close and trusting relationship with Dr. Zamani was maintained with Dr. Emal Khan—*"so that we are married to FPHC!"*—the Administrator said in 2001. His own door was another observed to be always open.

The quotations from Boerma and Key do not make specific reference to the motivation of leaders of effective NGO/PHC projects, but prolonged and committed service to an ideology and an organisation suggest some exploration is of interest.

Leadership, dedication and motivation

It is comparatively easy to understand Dr. Zamani's dedication: at a critical time he was working for the benefit of his own people and preparing some for rebuilding infrastructure on return to Afghanistan. He obtained satisfactions outweighing the material gains which might have become accessible had he moved to the West in the 1980s like many of his contemporaries—*"the PHC project was my baby"* he said at interview in 2001. It is only because his life was endangered that he left Pakistan in 1991.

Both Dr. Emel Khan and Dr. Wagma told me of job offers from other organisations which they had refused, in spite of higher salaries. As an Afghan by birth, Dr. Wagma told me that

she was working for love of her own people, to maintain her interest in learning, and because she was unwilling to be limited to working as a private practitioner—"All my family were teachers", she said. Dr. Emel Khan is not Afghan, but as a Pathan, is acceptable to refugees and non-refugees. Khan families are regarded as rich, and as sources of leadership and practical help for the community, but in practice they do not always give it. A short spell of private practice in his own village after qualification taught him that poor patients could not always afford to buy drugs. Working in Baluchistan in the Refugee Health Programme helped his conversion to the PHC strategy. At difficult times, he said, and particularly during the crises of 1993/4 he took comfort from remembering his grandfather, who was a close friend of Badshah Khan.

This was Abdul Gaffar Khan, the "Frontier Gandhi", already mentioned. In the 1920s he founded the Khudai Khidmatgar Movement, or "Red Shirts" as they were popularly known, and his home village of Utmanzai is near Wardaga village in Charsadda District. Banerjee in her study of the Movement stresses not only his achievement in persuading Pathans, a people with a strong sense of personal honour and a warrior tradition, to adopt non-aggressive methods of protest, but also:

"his ongoing practical concerns about improving education and living standards lay in the cultivation of a greater sense of service in Pathan society"
(Banerjee 2000: 56)

The Movement was run on military lines, but without weaponry. Badshah Khan insisted on discipline and cleanliness, not only in Red Shirt camps, but by offering practical help from his men to local people with cleaning and repair work in villages. He himself, the son of a rich landowner, participated in these menial tasks (Banerjee 2000: 75, 77). Badshah Khan is still venerated in NWFP, and his surviving associates command respect.²¹

The idea of public service appears to have survived in Dr. Emal Khan's family and found expression in his FPHC work. Dr. Wagma's expertise and family tradition of commitment to her own and others' learning had drawn her to work where she could influence policy and practice. In my opinion, both parties appear motivated by a genuine wish to serve the community in preference to personal advancement, and both appear to obtain satisfaction from that.

²¹ Dr. Emel Khan's grandfather (now deceased) was one of those interviewed by Banerjee (2000: 228 no. 53)

Summary based on Rifkin's five levels of participation

Rifkin's framework of community involvement helps to assess how far this first of Macdonald's "Three Pillars" of PHC has been operationalised in the three agencies aiming to provide basic health care in NWFP. Even if the community is willing to become involved in responsibility for its own health care, effective provision requires specialist knowledge and expertise. Leadership by an able and insightful health professional accepted by the community facilitated at ARC/PHC a wider range of services via a larger staff team than at the other agencies.

1. Participation as patients: None of the three agencies was completely rejected by its target populations, but patient attendance varied widely between GOP BHUs. Refugees and non-refugees were accepted at facilities not originally intended for them, but only at FPHC was non-discrimination a formal policy. Some culture-based reluctance to let women attend persisted among refugees and non-refugees, more evident at newer or peripheral BHUs and Health Centres. FPHC had consistently higher attendance figures, though it had taken many years to achieve a satisfactory attendance by women. More recently registered village patients will probably become more participant as understanding of preventive and health promotive practices increases. In the GOP system, there was little understanding of PHC or of the principle of participation. Middle managers, carrying a heavy workload, were acutely aware of chronic problems. GOP's continuing bias towards curative work did not favour community participation beyond attendance as patients.

The exception observed was the Swabi GOP BHU, where a committed MO with some understanding of PHC, and probably with local political support, had initiated ways of compensating for an under-resourced service. This is an example of positive leadership; further research would be needed to discover other examples of transcendence of the system.

2. Taking part in activities: Health Committees did not have a high profile in any of the three agencies though all had made some effort. The 1995 "watershed" at FPHC stimulated more community-oriented work, by de-centralising training, and through other group activities for both men and women. But the tendency of male staff at Gandaf camp HC to equate literacy with knowledge and competence appeared to discourage women's involvement. In general, groups addressing women's specific interests were acceptable. In 2000, it was still early days for meaningful involvement by FPHC's Board of Governors.

3. Implementation: Volunteer workers are usually regarded as exemplifying community participation. This was the only evidence of this or any other level of involvement within the

Refugee Health Programme as a whole, apart from participation as patients. The doctor-led team of basic health care provision is traceable to in-country pressure to use the reservoir of unemployed Pakistani doctors. Training community volunteers may have led to them being perceived as assistants to professionals as much as community participants. At ARC/PHC/FPHC this did not appear to detract from their effectiveness as implementers of PHC and their acceptability within their own settled community.

4. Monitoring and evaluation: In the fourth phase of the health project's existence, anecdotal evidence of patients' ability to communicate dissatisfaction either individually or in groups suggest inklings of this fourth level of participation, though there is no formal mechanism. Internal reporting, meeting and supervision arrangements at FPHC were for staff only, but patients could expect to have their criticisms taken seriously by management.

5. Planning: The use of PRA later in FPHC's fourth phase indicates community involvement in planning, which management took into account in setting up the newer Health Centres. At Wardaga village, the demand for MCH/Family Planning resulted in a comparatively restricted service. Wardaga HC therefore cannot be said to be providing Comprehensive PHC. Staff were conscious of this, yet their own suggestion for development was to have a fully equipped labour room at the HC, effectively reinforcing its specialist nature. At another Health Centre, FPHC responded positively to a community request for pregnancy testing.

Conclusions

FPHC since the mid-1990s had achieved more community participation than either of the other two services in NWFP. GOP displayed none, with one local exception. Leadership of the Refugee Health Programme had changed many times during its existence, which cannot help continuity or development of a service which was innovatory in the 1980s when it introduced PHC and sponsored training of voluntary workers. It could expand training for health professionals beyond its long-standing rather mechanistic programme-based style, and provide more stimulation for long-serving staff.

By contrast, creative, charismatic (if authoritarian) and indigenous leadership was significant for the developing ARC/PHC project over the first ten years, but apart from volunteer health workers, there was not much community involvement. After the 1995 watershed, an internal promotion maintained continuity. A more flexible but still indigenous, and dedicated male/female professional partnership supported by effective administration built on its PHC

apprenticeship and used fresh learning to adopt a more community-oriented management style. Emerging involvement of the community in the higher levels of participation may have some effect on FPHC's practice and future direction—perhaps towards sectors other than health, but not necessarily unrelated to it, as the Declaration of Alma Ata recognised.

What has happened at Wardaga Health Centre—or rather what was chosen by the community—suggests that a possible side-effect of participation at the most advanced level i.e. planning is some modification or even distortion of the aims of an organisation claiming to provide Comprehensive PHC. Indeed any organisation concerned with any developmental activity may have to face a challenge to its aims because of demands expressed by the community which do not necessarily coincide with these aims, just as the organisation may have to contend with "projectitis " on the part of donors.

The next chapter will consider the principle of inter-sectoral collaboration.

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CHAPTER 7

THE SECOND PILLAR: INTER-SECTORAL COLLABORATION

The previous chapter dealt with the first of the “Three Pillars” of PHC, participation by people in the community. The chapter also noted the statement in **Article VII (4)** of the Declaration of Alma Ata that Primary Health Care involves “*in addition to the health sector, all related sectors and aspects of national and community development*”, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and “*demand the co-ordinated efforts of all those sectors*”.

This second pillar or principle of PHC, inter-sectoral collaboration, recognises that health is intimately connected with other aspects of life, such as food security, education (especially that of women), safe water and sanitation, adequate housing, job opportunities and income level, all affecting standards and quality of life or the lack of it, i.e. poverty. WHO's celebrated definition of health as “*a state of physical, mental and social well-being and not merely an absence of disease or infirmity*” indicates that health is not only a human right but that attaining the highest possible level of health is an important social goal whose worldwide realisation requires action by many other social and economic sectors besides the health sector.

The chapter starts by setting out different interpretations of the principle of inter-sectoral collaboration, including references to Pakistan and to the specific and complex circumstances in NWFP. The chapter assesses how far ARC/PHC/FPHC has managed to implement inter-sectoral collaboration, and in what ways, throughout its developmental phases. It assesses reasons for limitations on inter-sectoral collaboration generally and on FPHC's efforts, and how these relate to the Pakistan context. It uses interview data gathered mainly during fieldwork visits. Some material has overtones of the two other “Pillars” of participation and equity, for all three are interlinked.

Types of inter-sectoral collaboration

1. Collaboration between government departments

The list of sectors in Article VII (4) above includes agriculture, housing, education, public works etc. which within any one country usually have individual government Ministries or Departments with these titular responsibilities. The Declaration of Alma Ata laid the responsibility for PHC on governments; the principle of inter-sectoral collaboration in health care expects co-ordination between the Ministry or Department of Health and other government Departments. Co-operation between various Departments in the interests of the health of the population is the most straightforward interpretation of the principle of inter-sectoral collaboration.

The Declaration's perspective is a global one. In practice, within any one country, Ministries or Departments are compartmentalised, as overseas aid agencies and professional attitudes (not only medical ones) may also be. Planning for the nation's health becomes "Health Planning" by officials, operationalised via medical-oriented systems and programmes, which can obscure the significance for people's health and well-being of a more co-operative approach.

"Fostering the participation of the community is one challenge. It is quite another to integrate the contributions and programmes of different Departments or sectors into efforts to attain overall health goals" (Hill 1997: 11)

Integration is far from easy to achieve administratively. An established pattern of bureaucracy which centralises control of all kinds of supplies and retains all authority at the most senior level inhibits co-operative initiatives at junior levels. A centralised pattern may not be confined to a Health Department, but may be the norm in other Ministries as well. Chakrabarti, Rutter and Worley stress that Pakistan is particularly prone to the 'departmentalism' factor, whereby ministries rarely operate outside their strict vertical responsibilities with little or no overlap (1989: 73).

2. Collaboration between societal sectors

A societal view of the term "sectoral" is also legitimate. As noted in Chapter 5 on NGOs, Green and Matthias identify three sources of health care, namely government, private agencies and NGOs:

The governmental sector: a Government Health Department, having ultimate responsibility for the people's health may choose to distribute actual service-delivery

between its own institutions and the private sector. It probably retains some regulatory responsibility.

The private (for profit) sector; operates according to free market principles, that is, in response to demand. It is unlikely to be concerned with public health problems, nor with the problems of the majority i.e. the poor, nor with remote areas.

The NGO or voluntary not-for-profit sector often provides a variety of services, directly through centralised institutions such as charitable hospitals or indirectly through specialist NGOs. An example within Pakistan is the Family Planning Association of Pakistan (FPAP). Some specialist NGOs may also run direct service clinics or function as donor organisations, as does Oxfam.

Even if these three sectors exist in a country, this does not mean that all health needs are covered. Co-operation between these sectors, each of which may include a number of different agencies, cannot be presumed. Certain factors (common to developing and western countries) do not encourage practical collaboration between these three sectors:

- competition is inherent in the private sector
- rivalry exists also among NGOs, sometimes as duplication or overlap
- independence and autonomy are valued both by private agencies and by NGOs; both are wary of too close a relationship with government
- the NGO sector distrusts the profit motive¹

Collaboration of a kind may occur when member organisations of one sector e.g. NGOs (each of whom may have a different field of interest) may come together to discuss common problems at least occasionally, even regularly as participants in an umbrella organisation. That does not mean that they are willing to work together at grass-roots or service-delivery level. This is well illustrated in NWFP, where what Godfrey calls "*the multiplicity of agencies working on behalf of refugees*" (1993: Abstract) led to the creation in the late 1980s of ACBAR (Agency Co-ordinating Body for Afghan Refugees), based in Peshawar.

At interview in Oxford in December 2001, Jon Bennett, Director of ACBAR 1989-1992 was emphatic on this point of non-collaboration between NGOs. During his tenure, 150-200 NGOs had offices in Peshawar, working in various ways with and/or for refugees. These

¹ This last was demonstrated at the meeting in Peshawar University in June 1998 which I attended (mentioned elsewhere) when representatives of some small NGOs objected to World Bank staff referring to NGOs as part of the private sector. They insisted that as non-profit organisations they were quite separate from private bodies; they considered only themselves entitled to the term "NGOs".

NGOs were not necessarily all members of ACBAR, but practical co-operation in the field was not a feature whether they were members or not.² ACBAR did set up separate sector-focussed meetings (health, education etc.) attended by representatives of active NGOs (including ARC/PHC) but they did not lead to any practical co-operation. However, as an umbrella organisation ACBAR was able to act as advocate for the NGO sector in discussions with donors and the UN (Bennett 1995: 15). Another ACBAR initiative was setting up the Afghan Resource and Information Centre (ARIC) which consisted of a library, an NGO database, maps, press-cuttings, copying facilities etc. available to any enquirer as well as to member NGOs.³ Noting the unique close-knit circumstances of the NGO community in Peshawar in the early 1990s, even though they did not combine practical work in the field, Bennett says

"ACBAR simply facilitated and improved upon an already high level of communication between agencies" (1995: 22)

3. INTRA-sectoral collaboration

Macdonald is critical of what he calls the lack of **intra-sectoral collaboration**, another interpretation of the principle, which needs explanation and examples to locate it in the Pakistan context. Government departments being by their very nature compartmentalised, they find it difficult to think in terms of collaboration with other departments or sectors; but in addition:

"Even within the same sector and programme, different divisions can develop working practices in isolation from other subsections in their own discipline. In health care, this is a common phenomenon: not only are 'public' health and curative care well separated from each other, it also happens that programmes such as health education can be quite separate from others like immunisation and mother and child health" (1995: 110-111).

In Pakistan, there is evidence of this separatism:

Failure to integrate programmes

Some preventive or health promotive programmes or facilities have never been integrated within GOP's BHU system. Centrally managed Polio Days and TT injection campaigns are not ineffectual—EPI in particular seems to be well-regarded (LaFond and White 1993: 19; Malik and Nazli 1999: 366)—but this is not an integrated way of working as envisaged in the PHC strategy. Separate vertical programming contributes to staff and patients' perception of

² ACBAR itself experienced some internal non-collaboration. Some Afghan NGOs formed a break-away group, ANCB (Afghan NGO Co-ordinating Body); some of these were very small enterprises set up simply to carry out short-term construction work on contract, according to Bennett.

³ ARIC was still functioning in Peshawar in 2002, based in the ACBAR Office, but by that date the membership of ACBAR itself consisted of NGOs working only in Afghanistan.

the BHU system as curative and limited, whereas it purports to be a comprehensive basic health care provision for the people.

Persistence of specialist clinics/dispensaries

Another instance of intra-sectoral non-collaboration is the continued existence of GOP Dispensaries and specialist MCH Clinics in some areas, whose activities overlap with services available (or supposed to be available) from BHUs, but which are independent of the BHU system. As noted in the chapter on PHC, in Pakistan there is a tendency for new schemes to be introduced without arranging for units set up under earlier programmes to be closed down. The Wardaga village women patient group explained to me in 2001 that official responsibility for vaccinations lay with a member of staff from a GOP Dispensary, not with the GOP BHU which is Wardaga's official source of comprehensive health care.⁴

Inconsistent allocation of federal/provincial responsibilities

The splitting of governmental responsibility between Federal and Provincial authorities in Pakistan adds still another element to the lack of intra-sectoral cohesion. Most governmental health provision in Pakistan is delegated to Provincial Health Departments, but management of the Prime Minister's Scheme for Lady Health Workers (LHWs) was retained at Federal level in Islamabad. There were no official arrangements for linking them with existing units. Separating activities and supervision of this scheme from the BHU system administered by the Provincial Health Department blurs the roles of both, and ignores opportunities for, or even creates obstacles to possible ways of joint or integrated working. A senior doctor at TVO criticised the failure of the scheme to cover remote areas, although he had a positive view of the training provided for these workers. His comment confirms poor intra-sectoral communication, when introducing the new scheme might have offered a fresh opportunity to address the chronic problem of deployment of female staff.

The restricted nature of intra-Departmental activity was illustrated at middle-management level by the EDOs (Health). The frustrations and pre-occupations common to all of them, which they shared with me (indeed ventilated readily) confined them to intra-District activity. They had no official opportunity for regular communication with each other as health professionals, unless they were summoned to a joint meeting on a specific topic called by the Provincial Health Department in Peshawar.

⁴ The women said his practice was to arrive in the village irregularly and unannounced. He vaccinated such children as he could find; obviously this did not cover all children, and as far as the women knew, no records were kept, nor was there any follow-up. There was no contact between Dispensary and BHU staff.

4. A “de facto” additional sector in NWFP

The Afghan Refugee Health Programme does not fit completely into any one of the three societal sectors above—governmental, private or NGO. Chapter 3 explained its partnership with a number of NGOs. Godfrey points out (1993: 310, 335) that many of these had roots external to Pakistan. Their differing remits and systems of accountability (often related to underlying policies of donor states) may have made possible practical co-operation with each other even less likely, because of trans- and inter-national political complications. Their presence, and that of UNHCR and other UN organisations such as UNICEF, WFP and WHO adds additional layers to the societal concept of inter-sectoral collaboration. Perhaps that renders the Refugee Health Programme collaborative in the inter-agency sense, but it exists to serve a separate population, the refugees. The Deputy Project Director (Health) of the Afghan Refugee Health Programme interviewed in 2001 in his Peshawar office said he had a regular meeting with GOP health officials, but the GOP and Refugee Health Programmes are discrete and parallel systems. Because of its separate functioning, while comprising multiple constituent agencies, the system of health care for the refugees may be regarded as a fourth sector of the societal interpretation of inter-sectoral collaboration—a sector peculiar to the circumstances in NWFP.

This separatism is not absolute. It does apply at the first level of care, but from the beginning of the Afghan influx GOP allowed refugees to access its secondary level care, according to the Commissioner for Afghan Refugees (CAR, NWFP) interviewed in 2001.⁵ He said that GOP subsidised the three GOP hospitals in Peshawar by Rs 3 million annually; refugees were allowed to use out-patient facilities at one of these as well, as a first-level service. Collaboration of this kind, according to the Programme Officer (Health) of UNHCR “*has never been refused*”, a comment she also applied to the use of GOP BHUs by refugees. This latter practice was perceived more as informal cross-over activity than consciously planned policy; numbers of users were not available (but see footnote no. 4 in chapter 3). That the Refugee Programme BHU teams are almost all led by Pakistani doctors may seem an example of collaboration between GOP and the Programme, but as previously mentioned this was a convenient way of finding employment for some surplus medical graduates: it was not a deliberately collaborative policy.

Locating ARC/PHC/FPHC: which sector?

It seems obvious that the health project of ARC belonged to this last sector, the Refugee Health Programme. However, ARC was a presence in Peshawar, active in the health field—

⁵ As noted in chapter 3, GOP was not the only provider of secondary care to refugees: several NGOs set up specialist hospitals in Peshawar.

admittedly on a small scale—by the summer of 1980, before the start of the official and much more extensive Refugee Health Programme later that year. In due course ARC was formally recognised by the Programme and allocated partnership status (Godfrey 1993: 405), maintaining its autonomy and NGO identity. As it also moved into fields other than health care by creating new projects (see chapter 3) it was the PHC Project which in practice became the collaborator in the Refugee Health Programme.

There is evidence of different kinds of collaboration by ARC/PHC/FPHC throughout the 20-year period of the case study. 1995 however was the watershed for significant change in collaboration, as it was for participation. This will be shown later in the chapter.

ARC/PHC/FPHC: inter-sectoral collaboration

ARC/PHC and the Refugee Health Programme : 1980-1984, 1985-1989, 1990-94

My notes on the ARC 1981 Annual Report mention the then Director's opinion that there was "*continuous exchange of experience and good co-ordination*" though it is not clear whether this means with UNHCR/GOP or with other NGOs through meetings which the Report says ARC had initiated. If the latter, it supports Bennett's conclusion that ACBAR (constituted 1988) simply improved on an established high level of communication between NGOs. UNHCR (a partnership agency, according to the firm statement by staff in the UNHCR Office in Peshawar 2001) and other UN agencies e.g. WFP were distributors directly to camp refugees of basics like food and cooking oil. They also distributed to NGOs including ARC substantial equipment such as vehicles and medical supplies. While this facilitated functioning and development of NGO services, it is possible that NGOs as first and foremost autonomous bodies saw UN agencies as providers rather than as partners in a collaborative relationship. Accountability of the ARC Office in Peshawar was to the ARC Vienna Board, which also acted as provider of goods, income and professional consultants from within Austria.

In the earliest ARC phase also (1980-1984) as the Refugee Health Programme developed a range of courses open to all personnel involved in health care, ARC's health project led by Dr. Zamani made extensive use of these by sending groups of staff to learn about control of diarrhoeal diseases, EPI, etc. This appears to qualify as **intra-sectoral collaboration**, inasmuch as the health project by adopting and implementing PHC—the official Refugee Health Programme policy—was incorporated into the Refugee Health Programme. At ARC/PHC, refugees accessed the full range of PHC-oriented health care at any one visit to a fixed station—BHU/later Health Centre—as the various components were introduced to the

health project. It was an integrated basic health service for three camps, integrated to a much greater degree than GOP's system. It is probable, however, that the growing self-sufficiency and semi-detachment of the health project from the Peshawar office under Dr. Zamani's leadership reinforced the perception of the Refugee Health Programme as a resource.

Within the ARC health project itself: inter-sectorally

Education

As the health work developed its settled and separate "project" identity, and new PHC-type activities were added, links with sectors related to health also increased, sometimes in the face of resistance by camp residents. Under Dr. Zamani's direction, money from St. Johann School in Tyrol funded the first Children's Play Park adjacent to Gandaf camp. Social education through play was supplemented by formal education for about 30 young girls, where links between health, education and income generation were further strengthened by incorporating instruction in basic literacy, health education and craft work; sewing machines issued to girls at the end of their several years of attendance were intended to help boost family income.⁶ The Play Park/girls' classroom initiative was the result of a visit by some Austrians who expressed a wish "*to do something for the children*", combined with Dr. Zamani's appreciation of the comprehensive and inter-sectoral nature of PHC, and his ability to get things done.

In 2001, senior staff said that resistance to education had been not only because of gender prejudice, but because there was general disapproval of education among the refugees: the educated Marxist elite was held ultimately responsible for the political disruption in Afghanistan which had fomented all the subsequent turmoil and flight from the home country. Staff told me they believed that school attendance by boys in the camps was limited to about 30-40% of its potential. In this early phase of the health project, it was insightful and determined leadership which confronted prejudice against education—of girls in particular—but for some years this was limited to one camp.

In its third phase 1990-1995, ARC/PHC set up a second Play Park and girls' class at Baghicha camp, after overcoming some reluctance by camp elders. By the time of the creation of FPHC in 1995, these negative attitudes had largely faded and the third Play Park and girls' class at Kagan camp was not only immediately welcomed as soon as money became available for construction, but acquired a waiting list for places once the class was full. Villagers as well as camp residents allowed their daughters to attend.

⁶ As there was no follow-up of what use was made of these machines, it is not possible to assess the outcome of the policy. Some machines may have been sold on, short-term needs taking priority. By year 2000 FPHC had introduced no other means of income-generation; refugees were free to use their own initiative, including seeking employment.

ARC/PHC also created links with boys' schools in the three camps by sending staff to give talks on health education, and by introducing medical examinations for pupils. Demands on staff time prevented these examinations from being as regular or as frequent as envisaged, but it was in any case policy that children (not only pre-school children) could be taken to BHUs/HCs at any time during working hours.

Safe water and sanitation

In the first phase 1980-1984, responsibility for these was entirely separate from ARC, and retained by UNHCR. Thus UNHCR itself showed an immediate understanding of inter-sectoral influence on health, by supporting water and sanitation installation in the camps by the NGO Enfants du Monde, even before the Afghan Refugee Health Programme started, according to Dr. Zamani's recollections at interview. This illustrates the tendency to regard safe water and sanitation as belonging to a sector other than health. Walsh and Warren, in advocating SPHC, quoted by Macdonald (1998:113) ruled out safe water and sanitation programmes in their proposed interventions. But safe water and sanitation are not separate from PHC, being one of its eight components. The SPHC exclusion possibly reflects an attitude that these are matters for engineers rather than health professionals.

There are two reasons for the continued separation of water and sanitation from PHC in its early phase and beyond:

Firstly, the ARC Sanitation and Basic Health (SBH) Project started later than the health project.⁷ SBH began in 1982, effectively taking over the work started by Enfants du Monde and continued by DACAAR, the Danish agency.

Secondly, there is a difference in work-style between SBH and PHC. The community approach of the SBH Project enabled peripatetic activity. SBH deliberately involved communities in installation, and having ensured that local people had learned maintenance skills, moved on to another location.⁸ ARC/PHC Team Sanitarians (and later Community Health Supervisors) supervised maintenance. To that extent the health project collaborated in responsibility for water and sanitation. In contrast to SBH activity, the PHC project was static, being a response to people's ongoing need for health care. Once fixed stations (BHUs/HCs) were set up, the settled PHC Project was free to promote a wider range of activity and involvement by camp communities. Commonsensically also, in the early days of

⁷ This project eventually separated from ARC in 1992, becoming the NGO Pak-CDP (Pak Community Development Project). It operated in Pakistani villages and since 1999 in new or re-opened camps set up to cope with the "drought" refugee influx from Afghanistan (interview with Director Pak-CDP 2001).

⁸ The three successive expatriate managers of SBH (all VSO volunteers) firmly believed in the community approach. In 1992 the second of these explained that it was slow, but the effect was more likely to be permanent, once the community had acquired appropriate skills and "ownership" (MMP Journal).

small ARC health teams of 2-4 persons working very long hours, it would have been a relief in the face of huge patient demand to know that providing safe water and sanitation was managed by other agencies with appropriate specialist expertise.

Nutrition

In ARC/PHC's first phase, various degrees of malnutrition were evident among young children (ARC Annual Reports 1984: 12, 1985: 22). Dr. Zamani's insight into the links between health and education stimulated him to use bribery as a behaviour modification technique, as noted in chapter 3. Later he started "demonstration kitchens" at each of the ARC/PHC BHUs (ARC Annual Report 1988: 14), where mothers (or big sisters or grandmothers) received instruction from LHVs or the team *dai* on preparing dietary supplements for pre-school children. At ARC/PHC kitchens mothers also received practical instruction on introducing mixed feeding to babies, the usual custom being to delay weaning until the second year.

Community initiatives at ARC/PHC in inter-sectoral collaboration

Daily life as individuals and communities experience it is not sectoralised or compartmentalised. Macdonald declares

"Community assessment often reveals the links between different aspects of life at the community level; people's medical needs, water and sanitation and nutritional needs are all interlinked in the life of that one person or community"
(1998: 115)

In its life as ARC/PHC, the health project did not use community assessment. The camp people took action of their own accord on some health-related matters:

Housing

The original refugee camps were literally just that: people lived in tents provided by UNHCR—the camps were "tented villages". Tents are inadequate in the cold wet winters of NWFP, and in summer can be unbearably hot.⁹ The refugees themselves began to build mud-plaster houses, following traditional fairly rapid methods of construction. The houses were (and are) basic, but comparable with local village standards. My notes give no exact dates for the start of this activity, but it seems to have begun soon after the camps were set up. There seems to have been no UNHCR/GOP interference (or support) with construction; it is unlikely that there was any responsible UNHCR/GOP Department. Chapter 3 recorded Dr. Zamani's active support to camp residents by sending his staff to help with building.

⁹ The Director of Pak-CDP told me in 2002 of many child deaths among the influx of "drought" refugees in 1999, due to the heat in the tents supplied in that emergency.

Income

Fieldwork evidence was that camp residents were very aware of their persisting poverty. Several patient interview groups mentioned the importance of income generation for improvement in health. Gandaf camp is the only one of the three served by ARC/PHC/FPHC to have increased in numbers, by about 10% in the late 1990s. Families were attracted from other camps by the chance of employment at the nearby Gadoon industrial estate, set up by GOP to discourage poppy-growing and provide alternative employment for local farmers. Employers had no objection to employing refugees—men only. But before opportunities arose at Gadoon, other enterprises by camp people included opening small shops; some men moved away to take up jobs, but would regard themselves as camp residents since families remained there and the men returned at intervals. In Mardan and Peshawar it was quite usual to see refugees hawking fruit, vegetables and second-hand clothing (the last recognisably western).

During fieldwork interviews, female patients, both refugees and non-refugees, expressed willingness to work. Chapter 6 mentioned an older woman at Gandaf camp who was explicit in her keenness to run a group to help women to work and combat poverty. But in general women, refugees and non-refugees, felt opportunities for employment were limited, either because of their own perceived disadvantage of illiteracy or because of cultural barriers. One long-serving Afghan doctor at FPHC recognised the links between income, education, housing and quality of life, but he did not suggest that responsibility for provision of these lay with any official agency. Even on probing he did not address the question of non-medical influences on community health other than as a matter of personal responsibility and initiative:

“What does a refugee do when he has a little money? He moves out of the camp and buys a house and sends his children to school”

For this man and his family self-help was possible because of assured, regular, above-average though still modest income. In 1992, he and his family lived in a large camp on the outskirts of Peshawar; when interviewed in 2001 they had been for some years living in a house in Mardan Town. In the circumstances of refugees in NWFP, individual initiative appears at least as active as officialdom.

Nutrition, gardening and agriculture

The spacious Play Parks were supervised by *chowkidars*, who were all camp residents. Having a rural/agricultural heritage and accustomed to coping with a difficult climate, they planted trees for shade in the parks. On my fieldwork visits, I saw that small beds of flowers

and vegetables were being tended inside the parks. The *chowkidars* explained that this was an attempt to educate the children, because so many were deprived of acquiring cultivation skills in the camps. Such loss is not total, for I have been in camp compounds where there were small vegetable plots, but “demonstration” vegetable-growing in the parks indicates understanding that health has many aspects and that it is important to promulgate that understanding. Another initiative by camp residents themselves occurred during one unusually wet summer in the 1990s, when Gandaf camp residents planted cereal crops on land adjacent to the camp previously regarded as infertile.¹⁰

To summarise: among both staff and patients at ARC/PHC/FPHC awareness grew that health is not exclusively a medical matter, and that there are ways of putting this into practice. Patients themselves understood the importance of housing; they had learned to appreciate safe water and sanitation;¹¹ children learned about growing vegetables, mothers were taught about improving nourishment. Much of this is small-scale and not inter-sectoral in the sense of being backed (or financed) by some responsible official agency or department but it indicates that ARC/PHC practised and encouraged a holistic attitude to health.

Educational initiatives although resisted in the beginning gradually became accepted, eventually welcomed, though probably not by everyone, because of some persisting gender bias. The curriculum for the girls’ classes included health education and became the responsibility of refugee women with a background in formal education. This cluster of educational provisions for young children and some girls, together with health education and medical examinations in camp schools can be described as inter-sectoral collaboration, but none of these were universally available within the three camps.

A note on collaboration within the NGO ARC

All the above relates to health-related activities at ARC/PHC in its first 14-15 years, while it became more self-contained, assured of regular funding from Austria. The ARC Office in Peshawar found new donors for the additional projects it started in the 1980s. That these projects started at different times and were funded by different international donors (NOVIB, Brot für die Welt, Oxfam) meant that collaboration was unlikely to be part of the agenda. Within ARC itself, therefore, practical inter-sectoral collaboration did not develop, although the projects—PHC, Sanitation and Basic Health, Technical Training—had a common purpose—improved quality of life for the refugees, of which better health is a part. Also, in the ARC

¹⁰ Officially refugees had no access to agricultural land in Pakistan, so this was probably illegal. Camps are usually in areas considered unsuitable for cultivation.

¹¹ In 1992 ARC/PHC had to forbid the removal of latrine slabs by those camp residents who chose to return to Afghanistan, obviously intending to use them there once they had settled.

years, all the projects had an additional purpose—to train people in skills useful on return to Afghanistan, irrespective of needs in Pakistan—an intention less relevant to collaboration.

When the Vienna Board accepted that the Rural Development Programme inside Afghanistan was operational, some members of the Board tried to promote “integrated rural development” by encouraging ARC to add health care to this project. This failed for several reasons, including misunderstandings over management responsibilities, and the crises of the early 1990s. As the different projects had no basis of integration in Pakistan, it was unrealistic to expect that they would achieve it inside Afghanistan.

The 1995 watershed: FPHC and inter-sectoral collaboration

Creating the independent indigenous NGO FPHC in 1995 with the remit of extension into the villages might have severed the connection with the Refugee Health Programme. However, by declaring in its formal documents that it would abide by its responsibilities to the original refugee group, FPHC was able to continue its partnership with the Refugee Health Programme and thus retain access to the material advantages of this intra-sectoral collaboration. Additionally, its new status as an indigenous NGO created opportunities for another kind of collaboration—inter-sectoral—with the private sector and with GOP.

Another option at the time might have been for FPHC to become internally more inter-sectoral. Zia Rizvi’s Transformation Strategy document of 1994 had proposed that as well as changing its status into that of independent NGO, and expanding into the villages, the health project should adopt an “*integrated rural development strategy*” (1994: 16-17). Senior staff rejected this on grounds of their lack of expertise outside the health care field, and also because they had recent experience of ARC’s difficulties, of which they were the sole survivors. The new NGO saw its priority as movement into villages, retaining its health service identity and obtaining new donors. Securing new donors was a serious preoccupation, for the infant NGO had entered a competitive market. Finances were for a time so precarious that management had to draw up worst case scenarios, identifying ways of reducing the service in order to keep going. This was not a climate favourable to fundamental changes in the project’s aims and work-style along lines suggested by Zia Rizvi.

FPHC and inter-sectoral collaboration : the societal version

Collaboration with the private sector

While ARC/PHC served refugees only, individual patients could approach a private practitioner outside Health Centre hours (8am-2pm, 5 days per week), if the CHW was unable to help. ARC/PHC recompensed the family for expenditure incurred, if they could show the need had been urgent. No formal arrangement existed between the health project and any private practitioner. After FPHC was set up and the target population increased to include local Pakistani people, working hours stayed the same but Health Centres increased from three to six between 1995 and year 2000. Patients could still contact private practitioners in emergency, but reimbursement ceased.

There has been virtually no collaboration between ARC/PHC/FPHC as an organisation and the private sector. Moreover, the health project forbade medical staff to practise privately within its own target area, whereas it was not unusual for GOP BHU doctors to do so within the same target area of the BHU where they officially served as MOs, as mentioned by staff at a GOP BHU in Charsadda District. FPHC's policy is justifiable in that private practice by its own staff, apart from appearing to be in competition with FPHC, would be along curative lines and could conceivably undermine FPHC's preventive and health promotive thrust.

Collaboration with other NGOs

Sandy Gall Afghanistan Centre (SGAC)

In 2001, senior FPHC staff considered that since 1995 there had been no day-to-day grass-roots collaboration with any specialised/professionalised NGO, particularly local NGOs, which could be described either as inter-sectoral or intra-sectoral. But there was one small-scale collaborative activity dating from ARC/PHC days. The Sandy Gall Afghanistan Centre in Peshawar (SGAC) which specialised in rehabilitation and prosthetics (mostly for men wounded fighting in Afghanistan) seconded two part-time physiotherapists to work between the various FPHC Health Centres. These two men worked with polio-affected children; senior staff from SGAC paid supervisory visits but day-to-day accountability was to the ARC/PHC/FPHC Team Leaders.¹²

Pak-CDP (Pak Community Development Project)

The most obvious large-scale collaborator, the NGO Pak-CDP (formerly the ARC SBH Project) had not followed up its surveys of villages served by FPHC by undertaking work on

¹² This was not a continuous collaboration; SGAC withdrew the two physiotherapists from FPHC in 1996 because of problems internal to itself, but was able to re-start the arrangement in 1997.

sanitation and water supply, as had been expected. This failure was at least partly because Pak-CDP suffered some internal disruption leading to a split into two separate NGOs. Within the three camps, the refugees continued to be responsible for upkeep of existing water/sanitation installations under FPHC staff supervision.

CBOs

In the mid-1990s, elders and/or CBOs in villages outside FPHC's target areas began to approach FPHC asking it to set up Health Centres. FPHC's response in the face of limited resources and anticipated management difficulties was to offer to send its Human Resources Team to train volunteers selected by the communities as CHWs, thus promoting community participation in health care. The Annual Report of year 2000 records seven of these courses provided in that year (pp 35-36). FPHC was also prepared to help with "technical support" to these CBOs e.g. helping them to frame proposals and requests for funding to possible donors.

Collaboration with donors

From 1995 onwards, the new NGO FPHC worked hard at building new relationships and finding new donors, most of whom were international NGOs. Although funding was a problem during and after transition to FPHC's new non-discriminatory identity, it was encouraging that some donors-in-kind e.g. ICD and FPAP were prepared to make no distinction between the two populations it served. They had previously donated for refugee needs only.

During group interviews in 2001, FPHC team staff interpreted collaboration as working with donors. As donors were almost all health-oriented, this could be regarded as intra-rather than inter-sectoral collaboration—or perhaps both. ICD's interest was tuberculosis, and FPAP provided training for some FPHC staff in contraceptive methods as well as supplies. Médecins sans Frontières (Belgium) had conducted research into malaria in the three camps in the 1980s and 1990s¹³. It recompensed ARC/PHC for this access by acting as examiner for Malaria Supervisors when they completed training at ARC/PHC's short-lived Residential Training Centre. The Training Centre in accepting students from other NGOs further exemplified intra-sectoral collaboration of those years. VSO (UK) provided a series of expatriates with a variety of skills to both ARC and the health project during the 1980s and 1990s—English language teachers and environmental health graduates, as well as MMP and JSP.

¹³ This is perhaps the only exception to ARC/PHC's non-collaboration with other NGOs, apart from seconded physiotherapists; but MSF's in-camp activity was research rather than service-delivery. Some patients benefited from free distribution of impregnated bed-nets.

A new donor introduces a new technique: inter-sectoral collaboration after 1995

A significant new donor was The Asia Foundation (TAF). TAF's interest being in promoting community participation via PRA, it made an award specifically for Health Centre at Wardaga village conditional on using PRA, providing training in this technique to FPHC. Macdonald's observation quoted earlier in this chapter on the inter-linking of needs is borne out by the experience at Wardaga village. In response to the villagers' request for a Health Centre, FPHC uncovered via PRA other community needs such as employment and education. PRA at Wardaga village (and later at Ismaila) thus encouraged the community to articulate its needs more explicitly; it also illustrated the fusion described by Macdonald:

"It is only on the level of providing of services, the bureaucratic level, that housing, disposal of waste, medical needs etc. get divided". (1998: 115)

He suggests that

".....public health workers should focus on inter-sectoral programmes at community level. Such programmes can create structures which allow women to organise around health issues" (1998: 120).

Limitations on inter-sectoral collaboration by FPHC

The question then arises as to how a NGO with limited and specifically focussed resources responds to emerging community needs—when it has encouraged the community to express these legitimate health-connected topics—but they mostly lie outside the restricted finances and official aims and remit of the NGO. If FPHC were to tackle needs revealed by PRA, and change its practice along the lines suggested by Macdonald, its Governors would have to consider re-drafting aims and objectives. Further, donors grant money for specific purposes (often very precise) and expect it to be spent accordingly. If an NGO strays from declared objectives and re-directs money not in accordance with the donors' expectations and formal agreements, it puts itself, its service and its target population at risk.

Wardaga Health Centre staff, sensitive to the continued omission of safe water and sanitation from FPHC's programmes, said they had in the absence of funding advised individual villagers to approach neighbours who had their own electric pumps and generators to ask for access, deep wells being a reliable source of water. Staff reported some positive results, with reduced dependency on water from the canals for household purposes, including drinking.

Macdonald's suggestions for inter-sectoral activity at community level echo Zia Rizvi's proposals for integrated rural development, which management rejected in 1994. By the time PRA was used for needs-assessment at Wardaga and Ismaila villages, FPHC had

become a stronger organisation and might conceivably have reconsidered. Dr. Emel Khan said to me in 2001 that he thought it not impossible for an NGO to move into integrated development, but he believed it was important that integrated health care along PHC lines should be achieved first. While this may appear evidence of “medicalised” thinking, in spite of Dr. Emel’s conscious conversion from curative care to PHC, it is probably reasonable not to push FPHC into attempting too much. If this NGO can be effective in providing something which approximates closely to CPHC, dilution of its service may be risky. Also, like most NGOs, its financial situation can never be regarded as secure—considerable energy is needed to pursue essential income. In his 1998 External Evaluation, Zia Rizvi pronounced that FPHC was

“a success story...a service-delivery organisation. It is geared to deliver health care, a service that is in universal demand, quickly and easily to rural communities” (1998: 13, 25)

and he did not this time round suggest that management adopt an integrated rural development policy.

The Wardaga community had decided that its health priority was MCH, and that is how the new service at Wardaga was organised, without the full range of integrated programmes obtainable at other FPHC Centres. Additionally, the PRA process effectively galvanised the community into setting up a formally constituted CBO, the Wardaga Welfare Society, replacing the previous informal group. The new CBO pressurised GOP Departments to fulfil obligations, and the Women's Section of the new NGO and village Breast-feeding Groups enabled women to discuss and bring about improvement in staff attendance in village schools, followed up by repeated monitoring visits. So a local structure had been created which did allow women to organise around health issues, and the CBO became a focus for community concerns and action.

Perhaps the less-than-comprehensive nature of the FPHC service at Wardaga Health Centre did not matter all that much, so long as activities related to the original focus of the NGO—in this case health—generated sufficient confidence for the community to become better organised and articulate legitimate demands. This underlines the close relationship between these two pillars of PHC, namely participation and inter-sectoral collaboration. A village community cannot revolutionise relationships or lack of them between government departments, but if it finds a voice through organised activity such as a CBO, it has a better chance of getting some results from the existing system.

Limitations on collaboration with government:

initiated by FPHC

Chapter 5 mentioned attempts in 1994/5 and later in 1996 to interest the Federal and Provincial Health Secretaries in FPHC as a possible resource for GOP. Neither effort was successful. In 1996 also, the Family Health Project in Peshawar agreed to meet with FPHC's representatives, but failed to respond to a written proposal, in spite of persistence by the NGO.

Once work in the villages had become established, Dr. Emel Khan started some outreach activity, capitalising on his interpersonal skills. He negotiated the transfer of an unused GOP BHU building in Ismaila village as premises for a new FPHC Health Centre there, consent for this transfer being granted by the District Commissioner. Dr. Emel Khan also approached local non-camp schools who agreed to health education for pupils by FPHC staff, and also to medical examinations—the official school medical service was non-functioning. Dr. Wagma reported in 2001 that FPHC staff had suggested training GOP teachers in health education. At one FPHC Health Centre, LHWs of the Prime Minister's Scheme accepted an invitation to join refresher courses run by FPHC's Human Resource Development Unit for its own staff.¹⁴ But in year 2000, the Provincial Education Department was still refusing to admit girls who had attended FPHC classes to its own schools: at least some of these girls were Pakistani.

initiated by GOP

In the late 1990s, the EDOs (Health) in Mardan and Swabi approached FPHC for help with Polio Campaign Days.¹⁵ They also asked FPHC to assist with vaccination and TT injection of villagers in their Districts, but outside FPHC's target area, supplies to come from GOP sources. Collaboration continued, though supplies were not always reliable, and GOP did not always thank FPHC for help given. These exercises were relatively small-scale and localised. GOP staff appear to have regarded FPHC as a convenient reliable agent; there did not seem to be any recognition of policy implications.

The most senior level of government showed no interest until 1999-2000, when the Provincial Health Minister Dr. Shaheen Sardar Ali acted on what she saw on her trips to the field (but see the section below). She was impressed by FPHC's work and how local people supported it. She initiated discussions on possible co-operative work between Health

¹⁴ The MO at the GOP BHU in Swabi District had also tried to implement some inter/intra-sectoral collaboration by having regular meetings with the LHWs in his area, and by sending some of his staff to give health education in schools—all on his own initiative.

¹⁵ This is in spite of the negative opinion of NGOs in general expressed at interview by one EDO in 2002.

Department and FPHC, but she was aware of vested interests and resistance from Health Department officials. Dr. Emel also experienced this when he attended meetings at the Minister's invitation. The Minister's statement that she herself learned of FPHC "*through mutual friends*" demonstrates a lack of interest or even awareness on the part of Health Department staff about what is on-the-ground in the Province. In 2002, FPHC hoped that the new Health Minister (also a woman) would resurrect negotiations to explore ways of working together in NWFP.

A missed opportunity for inter-sectoral collaboration

In 1995, the Government of Pakistan made a nation-wide attempt to involve NGOs in working on some long-standing social problems: potential collaboration between the governmental and NGO sectors. GOP publicised the Participatory Development Project of its Social Action Programme (SAP/PDP Phase 1). It sought proposals from NGOs under four separate headings as follows:

- Education
- Primary Health Care
- Family Planning
- Basic Water and Sanitation

SAP/ PDP budgets were separate, and applications were required under the specific headings. GOP therefore did not take on board the possibility of an integrated approach towards a common goal, either between organisations or within any individual organisation which might have been prepared to work in that way. If it had been, then two of the "Three Pillars", namely inter-sectoral collaboration and participation, might have been jointly addressed. It looked as if GOP while aiming at collaboration in societal terms had missed an opportunity for collaboration subject-wise, or intra-sectoral collaboration in health. FPHC had already combined Family Planning with its MCH work and regarded itself as providing an integrated basic health service. However, FPHC was glad to win the maximum award of Rs 7 million from SAP/PDP 1 covering the two years 1996-1997, which eased its financial situation considerably. This created a new link with GOP, which recognised this NGO as having a contribution to make to the health care of some of its own nationals.

But SAP/PDP did not envisage any collaboration between its own health system and any NGO. In Pakistan, by year 2000, collaboration between the three sectors—government, private and NGO was not formally addressed. Government financial support as in SAP/PDP does not fit the Alma Ata concept of inter-sectoral collaboration (nor Macdonald's) because

it did not address practicalities like integration of personnel or day-to-day work between government, private and NGO services. PDP did appear a sincere attempt to tackle long-standing problems, but it could not be a universal solution. Awards to NGOs under SAP/PDP Phase 1 were made on a selective and competitive basis; it is difficult to see how else assessments of suitability could have been made, given the monetary limits.¹⁶

Globally, inter-sectoral collaboration between government, private and NGO sectors seems to be rare. Dr. John Seaman of SCF (UK) interviewed in London 11.12.01 knew of only one example from Papua New Guinea (no date given). The high incidence of the vitamin deficiency disease, pellagra, among plantation workers led to the formation of co-ordinating committees, following the recognition that nutritional problems required economic as well as medical action. However, he pointed out that this example relates to a specific condition, not to general health. The move was less concerned with the health of the many (including families) than with maintaining a healthy workforce to ensure production levels and support business interests—the profit motive. If families benefited, that was a side-effect.

Understanding and implementing inter-sectoral collaboration

If Dr. Seaman's allegation about the rarity of inter-sectoral collaboration is justified, and if SAP/PDP represents a missed opportunity, what evidence was there in Pakistan that people in general—and especially those with professional and planning responsibilities—understood the concept of inter-sectoral collaboration in such a way as to have some effect on health?

Education

Several interviewees suggested education as an important influence on health, notably senior staff at TVO, CIDA and TAF, all donors to FPHC. They cited the need for education of adults (including women) as well as children, and stressed GOP's unfulfilled obligation to provide basic education as well as health care. Staff working in CIDA's Women in Development Section emphasised the disadvantaged position of the girl-child in Pakistan, where son preference can affect opportunities and nutrition of growing daughters.

The EDOs (Health) criticised Health Committees and the public's perception of the basic service as curative, suggesting that the EDOs did see a need for health education, and education in a wider sense. One thought that poor educational facilities in remote areas contributed to the difficulty of recruiting health professionals for these distant parts, if they had children.

¹⁶ GOP made one award in NWFP under SAP/PDP Phase I to a private medical practitioner specialising in cardiac conditions.

Housing

The Health Minister of NWFP was the only interviewee to mention spontaneously the importance of housing, except for a senior staff member at CIDA, who had seen a family living in a cave. The restrictions on women and girls—keeping them within the family home—had in this case led to a deprivation of sunlight.

It may be that no relevant Department or authority exists for some sectors to act as a partner with Health or any other Department in the collaborative process. For instance, while land purchase and house-building may be subject to strict controls in the wealthy and expanding suburbs of Peshawar and Islamabad, in rural areas poor people seem to erect houses (at least of the old mud-plaster type) wherever suits them. The *katchi abadis* (slum houses) constructed more or less anywhere and anyhow by poor people are familiar sights in the cities, sometimes just over the wall from pleasant, even luxurious modern homes with well-tended gardens. It is not clear where responsibility for oversight of these self-constructed houses lies, nor whether Health Departments either Federal or Provincial, nor landowners, perceive any need jointly to address the health risks to which the inhabitants and perhaps the wider community might be exposed as a result of these conditions.

Planning

The Deputy EDO (Health) in Mardan regretted that health personnel were so little involved in planning. Macdonald supports this criticism, noting that health workers are not responsible for the overall approach of the systems or programmes in which they work and are often pre-occupied by the demands of their daily work (1998: 75). The EDOs were over-burdened by their obligation of inspection visits to 60-70 health facilities in each of their Districts, all of which had populations of over a million and included about 50 BHUs plus several other units such as hospitals, Rural Health Centres, some dispensaries and MCH clinics. All three EDOs interviewed had attended courses on PHC, but their understanding appeared to be confined to the eight components (see their comments in chapter 6). Given their medicalised view of health, it does not seem likely that they could be effective change agents even if they had a collective voice at planning level.

Many interviewees with professional responsibilities did demonstrate knowledge of significant links between health and other sectors, including as mentioned the Health Minister herself, who was explicit about the inter-sectoral links between health, housing and education, and sensitive to the need for change agents to activate new ways of working. But almost no interviewee went so far as to make explicit suggestions about practical collaboration between existing Departments. The exception was Dr. Shabina Raza

interviewed in London 4.07.2001, who conducted the External Evaluation of FPHC in 2000 and as a community paediatrician had a special interest in preventive work. She felt that the need for collaboration should be acknowledged and encouraged by the Health Minister—*"she should have talks with other Departments—we need to push them now!"* She suggested Planning and Development Department as a co-ordinating body, but the experience of SAP/PDP Phase I, for which P and D Dept. had overseeing responsibility was not encouraging. As mentioned, SAP/PDP Phase 2 failed to start.

Priorities

Fieldwork produced evidence of grassroots awareness of distortion in national expenditure and of excessive departmentalism on basic health care. One EDO (Health) thought national expenditure on health should be 6%.¹⁷ He complained about the dominance of Finance Department and the difficulty of getting any repairs done to buildings, utilities and grounds because of the split responsibilities between Departments, all of which had their own budgets. Health needs, including basic maintenance, were not a priority—*"it can take years to get a response to a request for work of any kind"* he said.¹⁸

Apart from this departmentalism characteristic of government in Pakistan, GOP has what Drèze and Sen describe as over-arching pre-occupations, particularly defence. Drèze and Sen note

"the exacting demands made on a country's resources (financial, human, scientific and other by military pre-occupations, very often at the expense of development" (2002: 278)

Drèze and Sen further argue that nuclear escalation, such as the explosions set off by India and Pakistan in 1998, increases rather than decreases insecurity in the sub-continent (2002: 284-285). All of this must push health planning and health services down the list of national priorities, including review or implementation of alternative health strategies based on an ideology of inter-departmental co-operation. Long-standing disputes such as that over Kashmir have deep roots which may take precedence over every-day needs of ordinary people—even in the eyes of the people themselves.

¹⁷ In 1996, Pakistan's military expenditure was 5.7% of the GDP, while GOP spending on health in 1990 was 1.8% of the GDP (HDR 1998: 170, 130)

¹⁸ MOs at the GOP BHUs made the same complaint about dilatory official responses to requests for basic repairs. Two of them had whitewashed their own rooms and paid for repairs to the BHU water tanks out of their own pockets.

Collaboration: effects on FPHC as an organisation

Before drawing general conclusions about FPHC's attempts at collaboration, it should be noted that these attempts whether inter-or intra-sectoral have reacted on FPHC's development and work-style. In the ARC/PHC phases, relationships with other bodies were managed via the Main ARC Office in Peshawar, where most refugee-oriented organisations were based. Creating a new independent Pakistani-registered NGO with a constellation of direct relationships entailed much travelling and attending meetings, more often in Islamabad than Peshawar (a 3- hour instead of a 1-hour drive). This ushered in a change in the way senior management had to organise work. The new NGO developed a higher profile, especially as an autonomous body, partly because it had to attract donors, and also because of the attention it attracted following the SAP/PDP Phase 1 award. By year 2000, Dr. Emel Khan was attending an average of 10 external meetings per month, including the following agencies:

EDOs (Health) in the three Districts in which FPHC functioned
 UNICEF
 WHO
 A newly formed group of local NGOs
 Three donor organisations—CIDA, TAF, TVO
 Provincial AIDS Consortium
 Population Welfare Committee of NWFP Government
 UNHCR

His time spent within FPHC reduced to about 25%. He had to delegate more supervision and inspection of FPHC Health Centres, giving other staff more responsibility, thus encouraging their personal development. He continued to substitute when possible for FPHC doctors on leave, and to be active in the field on Polio and TT campaign days. Dr. Wagma's role changed since 1995, from clinician via trainer to facilitator, using PRA, group and counselling methods. These techniques as well as encouraging community participation helped to reveal the relationship between non-medical factors in health and communities' own awareness of these.

Conclusion

In NWFP, three types of inter-sectoral collaboration—between government departments, between societal sectors and between departmental sections—were augmented by another, the many-layered Afghan Refugee Health Programme, in which ARC/PHC was a collaborator.

ARC/PHC displayed understanding of the holistic nature of health and health care, partly because of insightful management, which introduced social and formal education to counter gender bias and cultural reluctance. The second factor was the resilience and pragmatism of camp residents who improved their quality of life by building houses, seeking employment to bring in income, and growing food where possible. But apart from housing, none of these resources was universally available in the three camps. In spite of their willingness to work, cultural barriers restricted women's employment.

During the life of ARC/PHC, its main thrust was development of a basic PHC health-care service. Collaboration or integration was not a feature within ARC, nor of the NGO community as a whole, but the ARC/PHC Training Centre functioned briefly as a resource for some other health NGOs. There was some collaboration with specialist NGOs providing small-scale physiotherapy and conducting malaria research.

Transformation of the health project into the non-discriminatory NGO FPHC in 1995—partly a survival expedient—changed its perspective and work-style. It retained collaborative access to Refugee Health Programme resources, while free to seek new collaborators. A new donor helped FPHC to use PRA to assess community needs. Two local villages became more articulate and more aware of inter-sectoral influences. In one village galvanising of the community strengthened an existing group, effected greater involvement by women, and enabled collective pressurising of government departments to fulfil obligations.

Although FPHC made several energetic overtures to GOP from 1994 onwards, ignorance, disinterest and inertia at senior levels of the Health Department prevailed even after the intervening positive action of SAP/PDP Phase I. GOP in seeking the help of NGOs persisted in a compartmentalised approach and retained the status of donor, not practical inter-sectoral collaborator. FPHC benefited from SAP/PDP both financially and in reputation, but by year 2000 SAP/PDP Phase 2 had failed to start.

Local efforts at collaboration with GOP were more successful, whether initiated by FPHC or by GOP middle-management, some LHWs managing to cross Provincial/Federal boundaries. Senior Health Department management were not positively supportive, until the Health Minister involved FPHC in discussions with her Department, recognising it as a potential change agent. But by year 2000 no significant policy change had occurred. GOP Education Department did not respond positively to FPHC's educational work. FPHC's greater community orientation and openness to new techniques have linked participation with collaboration. Approaches from villages outside FPHC's target area asking for CHW training indicated FPHC's growing role as a resource. In spite of a persisting unpropitious

context, FPHC management did not appear discouraged or feel rejected. They remained hopeful that working on their increasing number of external relationships would favour opportunities for collaboration with other agencies—whether governmental or international.

The next chapter will consider the third of the “Three Pillars”, namely equity.

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CHAPTER 8

THE THIRD PILLAR: EQUITY—AND EFFICIENCY

The introductory paragraph of the Declaration of Alma Ata expresses the need *to protect and promote the health of all the people of the world*. Article 2 notes the discrepancy in health standards between the industrialised and the developing countries, and the unacceptability of this gap. Townsend and Davidson's classic publication "Inequalities in Health" (1982) expounded also on differences in health standards between social groups within each of these two categories, emphasising the relationship with poverty.

The Declaration continues

....."Primary health care is the key to attaining this target (health for all by the year 2000) as part of development in the spirit of social justice" (Article V)

because

"Primary health care addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly" (Article VII: 2)

The main health problems in a community are those affecting the majority; in the developing world the poor constitute the vast majority. The spirit of social justice invoked in Article V above is related to the third of the "Three Pillars" of PHC, that is, equity. Equity does not mean equality—the identical provision for all—but fairness, or justice in health, in the sense that those groups most in need should receive a service in proportion to that need.

Chapters 6 and 7 included material relevant not only to participation and inter-sectoral collaboration, but also to the third "pillar" or principle of equity. The "Three Pillars" are not separate from each other but are closely inter-linked. Rifkin, Muller and Bichmann in their article on measuring participation make the categorical statement that

"Participation cannot be divorced from equity" (1988: 931)

This chapter discusses not only equity but also efficiency, with some examples from Pakistan. However equitable in intent a health policy may be, it is efficiency in delivering health care which renders implementation effective and fulfils as far as possible the aim of equity. The chapter considers equity and efficiency in Pakistan in more detail, with some reference to the other two basic health care services in NWFP, and finally assesses equity and efficiency at ARC/PHC/FPHC.

Equity: the global picture updated

In spite of interest in PHC across the globe and efforts of many countries to implement it, nearly twenty years later, in an article focussing on public health in developing countries, Macfarlane, Racelis and Muli-Musiime stress

"Our message is universal. Poverty and health disparities exist and are increasing in all nations of the world" (2000: 10)

According to Green, (1994: 43), in 1978 the Declaration of Alma Ata propounded a broad and consistent philosophy and strategy for the attainment of Health for All the PHC approach. The original Alma Ata principles are very broad-brush, understandable in a fundamentally ground-breaking document. Discussing health planning for developing countries (with PHC in mind) Green op. cit. suggests that equity is rather a loose term, and needs more precise definition. Since 1978 the thinking about the "Three Pillars", including equity, has moved on and become more sophisticated. Equity, for instance, is now recognised as a topic for serious discussion in itself, as witness the creation of the International Society for Equity in Health (ISEqH) and its Journal. It defines equity in health as

"the absence of potentially remediable systematic differences in one or more aspects of health across socially, economically, demographically, geographically defined population groups or sub-groups" (Macinko and Starfield 2002: Abstract)

In considering primary health care for developing countries, Green suggests five simpler optional definitions of equity as follows:

- equal health
- equal access to health care
- equal utilisation of health care
- equal access to health care according to need, and
- equal utilisation of health care according to need (1994:55)

Without going into detail here, he rejects the first three of these as simplistic, impracticable or maybe even undesirable. He suggests that the last two come closest to the philosophy of PHC, *"bearing in mind the importance of social justice in the concept of equity"*. But *"access"* and *"utilisation"* themselves need definition, or at least a consideration of the factors influencing them. Noting that access is not only a matter of distance from a health facility, he says that ability to pay will affect access by poor people. However, he appears to incline towards the fifth definition of equity *"equal utilisation of health care according to need"* since this includes the distance and payment factors.

Equity in industrialised countries

To digress somewhat: even within industrialised countries where the right to universal health care is recognised, equity of provision cannot be presumed. Dr. John Reid, Minister of Health in the present UK Labour Government chose as a topic for a speech in November 2003 "Equity of Access", declaring his starting point to be that

"our basic values dictate that the use of services by patients should depend, so far as is humanly possible in our system, only on the need of patients for treatment and not on factors such as how much money they have" (Refugeenetwork Digest no.150)

In his opinion, even in a system as fair as the NHS, trying to get everyone "the same" or "equal" service is based on a fallacious argument. He lists five ways in which human beings are different from each other, relevant to their different health problems and health care needs: gender, race or ethnic origin, age, disability and socio-economic status. It is the attempt to cater appropriately for varying needs which is the route towards equity, or as he puts it, not more "sameness" but less, i.e. greater differentiation of services.

Macdonald's observations link with Reid's recognition of varying needs but go further. He makes a clear distinction between health differences which are inevitable i.e. those caused by biological processes such as ageing, and differences or imbalances between people and groups in communities:

"Inequity has a moral dimension, suggesting that what is being talked about are avoidable and unjust dimensions of unequal distribution of health resources and disparities in health status...The equity dimension of PHC concerns those differences in health status and access to health care which are within human control"

(Macdonald 1998: 124)

The implication (which echoes the ISEqH definition above) is that more resources should be directed towards those communities where need for improved health status is greatest, or more precisely in proportion to the need. In developing countries in particular, PHC is sometimes perceived by governments as a cheap service suitable for the poor, but this is founded on inadequate understanding of its comprehensive public health preventive and health promotive thrust, encapsulated in the slogan "Health for All" (Tejada de Rivero 1992: 158). The perception of PHC as a second-grade service ignores Green and Matthias' preferred definition of health as a human right, quoted in Chapter 4. On the other hand, positive promotion of it as a pro-poor service as in Malaysia since the 1970s is more in sympathy with adjusting imbalance between rich and poor, i.e. aiming at equity. Bin Uni stresses the deliberate efforts by the Malaysian government (1996:759-768) to provide PHC to the rural poor by (among other things) improving

infrastructure, using mobile health teams to reach remote areas, and making the service free to those who cannot afford to pay. The government also recognised that the private sector has a place, complementing the officially universal and comprehensive public health service, so that the Malaysian health care system is “*a mixed public-private system*”; but it has taken 38 years to achieve this (1996: 768, 763).

Factors in “access” and “utilisation”

But to return to Green’s concerns with “*access*” and “*utilisation*”: he quotes data from Townsend (1982) and Segall (1983) and also from a study in Zimbabwe to identify the following specifics in utilisation which are incorporated in three overall underlying factors in equity, viz., class race and gender:

- physical distance from the health facility
- costs, including fees charged, travel to and from facility, drug costs, lost income during time spent attending
- attitudes of employers to absence from work
- perceptions of need and of the utility of health care
- cultural constraints on the use of medical care
- attitudes of health professionals

Later in this chapter, I comment on staff’s understanding of the principle (see pages 222-224) and detailed some of the factors influencing equity as they occurred at FPHC and how staff made attempts to combat inequity as they saw it¹

Another perspective: horizontal and vertical equity

Green, who is writing from a government planning perspective, recognises the problems of governments with an obligation to resolve the inevitable discrepancy between needs and available resources for an entire national population. He goes on to discuss the concepts of horizontal and vertical equity (1994: 57). Horizontal equity implies equal treatment for equal need, e.g. all pregnant women without complications would receive similar care. He first interprets vertical equity as implying unequal treatment of unequal need (implicit in Reid’s

¹ *Physical distance*: see p 228 for staff’s admission that camp residents living nearer to HCs attended more frequently; p 223 re start of sub-clinic at Ismaila to facilitate service to more distant village women; p 228 re treatment of “guests”; also p 223 for references to outreach and follow-up work.

Costs: see p 229 for section on costs to patients; p223 for “poor lists” and special arrangements for patients with chronic conditions; p 213 for inconvenience to obligatory male escorts for women patients; this may also apply to employers’ attitudes to men’s absence from work; p 228 re payment by “guests”.

Perceptions of need: see p 213 on recognition of symptoms and decision-makers’ role re female patient attendance.

Cultural constraints: see pp223, 224 for gender training and changes in male/female staff ratio; also chart in Ch.3; Ch 6 for residual cultural inhibitions on women’s attendance at HCs; Ch 9 for acceptability of TBAs domiciliary visits.

Attitudes of health professionals: see Ch 4 for comments on staff attitudes; also Ch.6 p. 160-1 and 166-70

speech above), that is, differing levels of health provision can be made available, for example, for pregnant women expecting no complications from those with likely complications. This interpretation is not entirely applicable or relevant to the functioning or perspective of an individual NGO, or even perhaps of in-country NGOs in general, since these are autonomous bodies which can choose their sphere of activity, though hopefully with due attention to planning.

“(Vertical equity) also suggests different levels of care for pregnancy as compared with other health needs, such as those of coronary patients” (Green 1994: 57)

This second interpretation of vertical inequity seems more applicable to the service for a specified population of Afghan refugees in camps (i.e. starting from a clean slate) whereas the first interpretation takes it for granted that pregnant women (and their children) constitute a recognised target group i.e. with needs different from the generality of an established population—it is assumed they require unequal treatment for their unequal need.

For instance, in the earliest days of ARC (and before the introduction of PHC) the UNHCR/GOP medical service for refugees in camps could be said to apply a horizontal understanding of equity; it was in theory at least, universally available in a basic, even primitive kind of way. Mobile facilities provided a simple curative service, but as noted in chapter 3, in practice access/utilisation would have been limited to those who were able to get to the vans. Chapter 3 indicated that the ARC health project, with the support of the Austrian donors, reacted to the needs of pregnant women, perceived as a specially disadvantaged group—*“a value judgment”* according to Green (1994: 57). ARC set up a MCH clinic in Mardan Town, though its performance was somewhat erratic because of uncertain continuity of female staff. Later however as ARC/PHC became established, the MCH activities formed a substantial part of the work and on the formation of the new NGO in 1995, this aim was included in the “Objects” of the Memorandum of Association of FPHC (see chapter 3 for extract). In ARC’s earlier Annual Reports, the health work is recorded under the heading “Activities”. It is not until 1992 that the ARC/PHC Annual Report presents its work in terms of Programmes i.e.:

1. Diagnostic and curative: OPD, nursing care, laboratory service, pharmaceutical service, dental care.
2. MCH: antenatal and postnatal care, care during delivery, under-2 clinic, child spacing.
3. Preventative: EPI, malaria, TB control, control of diarrhoeal diseases.
4. Health promotive: home visiting, school health, health education.
5. Rehabilitative: nutritional rehabilitation, physiotherapy.

This suggests (as does targeting women and children) the development of vertical equity within a project claiming to provide comprehensive PHC according to the aims of the Declaration of Alma Ata. But I would argue that the apparent verticality is more a matter of convenience for explication and reporting purposes. Because all programmes are available to patients through the one door of the ARC/PHC/FPHC BHU/Health Centre where they are registered, this is a fully integrated PHC project with a justifiable claim to be horizontally equitable, certainly as far as its refugee “demonstration population” is concerned. Interviews with staff (from the Director down) and patients showed that they did not see what they were providing or receiving was rigidly compartmentalised or fragmented, but integrated. The exception (noted elsewhere) was the lack of the NGO’s responsibility for safe water and sanitation, but chapter 4 explained that this had been done at a very early stage by specialist NGOs commissioned by UNHCR/GOP to install systems throughout all camps, i.e. in keeping with horizontal equity.

An expanded version of equity

My assertion of the equitable nature of ARC/PHC/FPHC’s service categorises women as patients. But Green (1994: 58) is critical of addressing women’s needs in terms of passive receivers of health care, concentrating on their reproductive role, thus exemplifying how thinking about the principle of equity has widened to include issues of gender. Other writers such as Standing (1997:1-18) address the importance of professionally trained women such as health workers and teachers, who have huge potential for influencing health and education, and consequently development. In Pakistan, particularly in male dominated Pathan (including Afghan) society where women’s literacy and educational levels are especially low, these are significant factors in equity or lack of it (see SPDC Report 2000 later in the chapter). But ARC/PHC/FPHC made some efforts to improve matters via girls’ classes (recently re-named Vocational Centres) and by engaging a few young unmarried women for training as Assistant LHVs.²

Perhaps a reversion?

There is a recent development at FPHC which suggests a move in the direction of verticality. It is outside the time period of this case study, but I refer to it in the Annex “FPHC after 2000”. FPHC’s new Reproductive Health /Essential Obstetric Centre in Mardan Town, funded from Austria, accepts refugee women only. These may be refugees from the three FPHC camps and from other camps, also refugee women living in the local villages. This appears discriminatory,

² See p 223 for information on gender training at FPHC.

since the needs of Pakistani village women have long been acknowledged as similar to those of the refugees. It is not clear whether this was a condition of the funding, but at least superficially it does not seem to agree with the equitable intentions of the policy formally declared in 1995.³

Efficiency in health care delivery

Equity and efficiency are both terms capable of different definitions and rather loose use. Analysis requires them to be distinguished from each other, but separating them can be difficult, because efficiency is integral to equity. Further, it can be difficult to separate efficiency from effectiveness. It is possible to have effectiveness without efficiency: for example, many proprietary drugs are effective, but are expensive, which suggests possible inequity. The Declaration of Alma Ata and WHO support the use of essential drugs, if possible generic drugs – cheaper and in most instances as effective. However, costs (not only of drugs) are only one factor in efficiency, as the chapter explains later.

It is possible to have efficiency without equity. For example, a hospital may be justifiably recognised as providing effective curative care (i.e. for those patients who have access to it because of its location or their ability to pay—or both) but these conditions mean its service is inequitable. In Pakistan, army hospitals have a good reputation, but for a restricted clientele: the various systems of health care provision for specified groups such as the army and the civil service are essentially exclusive and therefore inequitable.

Chapter 4 explained Pakistan's failure to provide universal care in spite of constructive legislation and apparently well-organised schemes. Even the well-regarded GOP immunisation programme can provide an example of inefficiency. The Wardaga women's group complained of unsatisfactory practice by the vaccinator from the GOP Dispensary (see footnote no.4 in chapter 7). Immunisation, a vertical programme, is equitable in intention, being aimed at children, a vulnerable group; but in this locality at least, inefficient practice reduced effectiveness and resulted in inequity, because the service failed to reach all the target group.

Carr-Hill (1994) stresses the link between equity and efficiency. He criticises the assumption that emphasis on technical quality automatically leads to the provision of effective and efficient service, which is then deemed to be the most equitable. His opinion supports the PHC approach. PHC does not reject techno-medicine where it is of proven efficacy, as in the case of immunisation, but as in the Wardaga example, inefficient service-delivery negates equity.

³ Emmel (1997) suggests that WHO itself is moving back towards vertical programmes at the expense of equity.

Additionally, equity being about fairness, Carr-Hill agrees with others quoted above in saying it may be judged fair to be unequal, in the interest of equity. Regarding efficiency:

"Achieving efficiency is about comparing costs (or resources spent) and benefits (or well-being produced) of competing health care interventions and ensuring that resources are allocated in such a way as to maximise health gains to society"
(1994: 1189, 190)

This links resources and effective health care, appropriately differentiated, with a commitment to serving the population as a whole: an equitable aim. It is a statement with political overtones, both national and global, implying that a degree of altruism will be required from some privileged people (or nations) who may have to accept reduced standards for themselves in order that the needs of others may be better served.

Equity: Pakistan

The chapter on PHC showed that part of Pakistan's problem is that population growth offsets efforts at improvement, so that health indicators grow better very slowly. Equity, then, in terms of how Pakistan as a developing country compares with the industrialised countries is a matter for concern: its rank in the Human Development Index (in which health is a factor) has remained between in the 130-140 range throughout the 1990s, placing it consistently in the "Low Human Development" category.⁴ Within the country, there is evidence of several inequalities which have implications for providing health care.

Geographical inequalities

The first aspect of this is that Pakistan is geographically very diverse, including many different types of terrain, from the Indus delta, the spreading plains of the Punjab and Mardan to mountainous territory of the Salt range and further north, the mountains of the Hindu Kush and the distant glens and passes tucked away in their midst. Travel to or from these remote communities is often difficult by any kind of transport (including by air) because of unpredictable weather at all times of year; some communities are completely cut off from time to time by snow or flood. But even on the plains, roads may not be maintained or exist at all, so that some villages can only be reached via footpaths, at least for the last few miles. For service-delivery purposes, these rural communities can be as problematic as villages on the alluvial fans in the mountains. GOP faces huge challenges in attempting to provide health care in

⁴ HDI 1993: 132; HDI 1996: 134; HDI 1997: 139; 2002: 138 (total countries 173)

such variable geographical and climatic conditions and inadequate infrastructure, including inadequate public transport.

The second geographical inequality is the discrepancy between rural and urban provision. The urban population can access hospitals providing curative services according to techno-medical practice (although as Macdonald points out, life for the urban poor can sometimes be worse than for rural people (1998:126)). In villages, ayurvedic, homoeopathic or unani medicine may be practised, but is not always available. Malik and Nazli cite higher crude birth and death rates and IMRs for rural areas (1999: 331)⁵. They attribute rural disadvantages to neglect of basic amenities such as potable water and sanitation (1999: 331), deficiencies specifically mentioned by patient groups at Baghicha and Wardaga villages. Malik and Nazli also assert that the limited available health facilities in rural areas are not fully utilised. This was evident from fieldwork visits to GOP BHUs, where numbers attending were low. As explained in the chapter on PHC, GOP is by no means unaware of the low quality of services especially in remote areas and has over many years tried to rectify it, but with no great effect. The more remote the area, the less adequate is the health care provided by the government.⁶

Socio-economic inequalities

Disentangling the components of this kind of inequality is not easy, since there is considerable overlap—each affects the other, and there are links with geographical inequalities as well.

The most obvious inequality is the discrepancy in **income and wealth** between those who have and the have-nots, who in Pakistan constitute the majority. Pakistan is a very stratified society, with a relatively thin layer of privileged at the top whose wealth derives either from landownership or commerce. Such people are more likely to have access to goods and services, including health care, and to be able to afford them; the Declaration of Alma Ata promotes health for all. Where poor people do have access to health care, whether from GOP or a private practitioner, medicines may either not be available, or people may be unable to afford them. Townsend, Davidson and Whitehead note that that it is the poor who make less use of health services, whereas they are the people in greatest need (1988: 2, 79-81). Ironically, successful anti-poverty efforts may have the side-effect of rendering the very poorest harder to find, thus increasing the difficulty of targeting expenditure to them (Bin Uni 1996: 762).

⁵ IMR 1991: urban 68.9 per 1000 live births; rural 102.4 per 1000.

⁶ A woman patient at the Mardan GOP BHU who had migrated with her family from the Northern Areas said there was "nothing" there. A FPHC lady doctor who had just started work at Gandaf 2 (village) Health Centre said "I was very upset when I saw the way the people were living". Gandaf is the most distant from Mardan town of the villages served by FPHC, though not truly remote.

However, interpreting “poverty” as lack of finance is an over-simplification of inequality, for

“attention to inequality is perhaps more important than poverty per se. While poverty does cause deprivation and hardships for those affected by it, high degrees of inequality ingrained in the structure of society and the economy and reinforced by policy actions, contribute to a sense of grievance and injustice, promote despondency and anger, and generate social and political instability” (SPDC Annual Review 2001: Foreword)

The **societal stratification** characteristic of Pakistan is linked with **patronage**, which continues to influence decisions about appointments and jobs. Chapter 4 noted the influence of the local *khan* at the Swabi BHU and the rapidity of changeovers in senior posts. The same chapter noted Pakistan’s history of instability and insecurity, and its generally poor record of public services, not only in health. There are few opportunities for social mobility, so the poor tend to remain poor. In rural areas especially, education, one of the factors in social mobility, is not easily accessed. Gazdar’s review of poverty in Pakistan, quoted in the introduction to this thesis, described the constellation of associated disadvantages which affect health and are all evident in rural NWFP (1999: 241-315).

Gender inequalities

Development literature stresses that **women in the developing world are disadvantaged**, with special significance for their health. Patriarchal attitudes mean that women’s nutrition is likely to suffer because husbands and male children have first choice of food. Almost 90% of lactating and expectant mothers in Pakistan suffer from anaemia due to iron deficiency (Malik and Nazli 1999: 367). Women can earn status only through marriage and reproduction (Kazi 1999: 377) and son preference puts pressure on women to have more children, encouraging negative attitudes to family planning and thus increasing health risks.

These are all features of the male-dominated Pathan culture of Afghan refugees and local Pakistanis in NWFP, but in addition this culture displays distinctive features which can exacerbate gender inequalities. *Purdah* restricts women’s movement, though local *purdah* practices may vary—in one village women work in the fields, in another they do not—but women may find it difficult to seek treatment, since a male escort is obligatory, thus doubling transport costs and possibly inconveniencing the designated escort. They (or their families) may not think that their complaint (if they recognise it as such) justifies a visit to a BHU or hospital, or it may be left until too late:

"Even if a woman wants to seek medical help, she may be unable to do so since the decision to do so does not rest with her, but with her husband or elders in the family" (Ravindran 1999: 21)

The proprieties dictate that women are not examined by male staff, but GOP BHU staff did not include a lady doctor; women patient groups said they would like one. Remote BHUs may have no female staff at all, although the official establishment allows for more than one—a LHV and a Female Medical Technician. Chapter 7 indicated that reluctance to serve in remote areas persisted among women trained under the recently introduced Prime Minister's Scheme for Lady Health Workers. Even if female staff do serve in a remote area, they may be unwilling to work outside the BHU e.g. to do home visiting or TBA supervision. In remote areas, the chances of TBAs being trained are fewer than where training and supervision are reasonably accessible. An expatriate friend told me of a village in Mardan District which she had visited where there was no TBA at all—"the women just help each other," she said. Poor rural women are the most disadvantaged section of the community in Pakistan, according to Kazi (1999: 376). Their lack of access to education, and where they live, reduce their opportunities for gainful employment—clearly stated by Baghicha village women, who wanted a more committed teacher for their daughters (preferably one who lived locally), so that these girls would have a better chance in life. Islamic inheritance law entitles daughters to half the share of the sons' entitlement, but most women do not claim such property, particularly land.

Kazi explains that socially superior women and their families can use urban-based private medicine and are more likely to be controlling their fertility (Kazi 1999: 379). But *purdah* can affect them too: when we had a discussion in her house with a well-to-do Mardani graduate lady who chaired the management committee of the local school for deaf children, convention decreed that her husband be present. However, adherence to these norms of inequality can be modified. Even in the conservative rural areas of NWFP, older women have greater freedom of movement and may be less heavily veiled, wearing a *chaddar*⁷ rather than a *burqa*.

The Health Minister herself thought that *purdah* was less restrictive than it is made out to be, saying that she herself was in *purdah*—"I do not violate the dress code". She dismissed the all-enveloping *burqa*, to western eyes very strange, as "*a middle-class thing—once they get a little money they buy a burqa*"⁸. She agreed that many women are invisible, while she herself

⁷ The *chaddar* is a few yards of cloth, often white, big enough to cover the body and head, held so as to partially cover the face.

⁸ Western media portray the *burqa* as imposed on Afghan women when the Taliban assumed power in 1996, but it was widely worn both by refugees and by Pakistanis when we arrived in NWFP in 1991. As a guest lecturer in Edinburgh 29.11.02 Professor Denise Kandyoti called it "the national dress" of Afghanistan.

was *"at the top, and no-one has questioned my right to be a Minister"*, but she qualified this by conceding that *"the community at large fears female emancipation as likely to cause ripples in society"*.

Bearing in mind the recognised link between health and education, particularly education of women, women in NWFP are further disadvantaged. The overall rate of literacy in Pakistan in 1997 was 43.6% (male 53.4%, female 30.0%). In NWFP the rates were 50.3% and 19.6% respectively (SPDC Annual Review 2000: 225). Refugee women are even more likely to be educationally disadvantaged, given the long-standing prejudice against education noted in Chapter 7. There were no literate women in the refugee patient groups I interviewed, but some village women, notably in the Wardaga and Swabi groups, said they could read and write; the Swabi women said they were all literate, and all on some form of contraception.

The above demonstrates that gender inequalities overlap with other disadvantages. Health care for women is inequitable, and likely to be more so the poorer and more disadvantaged the community of origin, especially if it is in a remote area. The norms of Pathan culture are likely to be especially disadvantageous in regard to women's health needs, that is, all aspects of reproductive health

Other inequalities: physical and mental disabilities

The Declaration of Alma Ata mentions *"groups in most need"* and *"the under-served"* but in the context these appear general references to the poor and those in remote areas. Article VII (2) does link rehabilitative services with promotive, preventive and curative approaches to the main health problems in the community, and Recommendation 5 on the content of primary health care includes *"promotion of mental health"* along with the more usually quoted eight components in Article VII (3). In Reid's speech on equity, he mentions addressing disability. In the UK several Disability Acts promote inter-sectoral measures intended to normalise the lives of disabled people as far as possible and increase their participation in society e.g. modification to public buildings, pavements and transport, sheltered housing, special education, and obligations on employers. Macdonald quotes Werner in support of his proposition that equity should address the needs of disabled people as part of social justice in primary health care (1998:136).

I have seen no evidence of official provisions of this type in NWFP, nor in Islamabad, nor any special provision at BHU level. It was quite usual to see severely disabled men (not women) moving about in public perhaps on hands and knees, or if e.g. blind or immobile, being conveyed

by friends to a regular stance, where they made a living by begging. International and local NGOs were active—the school for deaf children in Mardan⁹ caused some families to move from their place of origin to get their children educated; the Sandy Gall Afghanistan Centre in Peshawar provided physiotherapy and prosthetics, but for men and boys only¹⁰. In Quetta, capital of Baluchistan, a Belgian NGO specialised in prosthetics using local materials.

The Vice-President of FPHC's Board of Governors (a local doctor), father of a physically and mentally handicapped son, some years ago started a small Day Centre for about 20 handicapped children, staffed by a few volunteers. It is funded by voluntary donations, raised mostly at the Annual General Meeting of the Day Centre. When we visited, the Centre was facing the problem of lack of follow-on provision; some handicapped people were continuing to attend though they were no longer children.

Mardan General Hospital had an in-patient Psychiatric Department staffed by a qualified psychiatrist (a local Pathan) and one unqualified assistant whom he had trained himself. Resources were limited to a ward of about a dozen beds for men (none for women) and a small sparsely furnished office for the consultant himself. He assured me (conversations in 1996) that he had had to fight (almost literally) for everything; at first no accommodation was provided at all, neither for him nor for patients.

Corruption

This is perhaps not so much a form of inequality in itself as a factor which pervades society and its institutions and services with significant consequences for efficiency, effectiveness and therefore equity. The literature does not pay much attention to corruption, but in NWFP it appeared endemic. Anecdotes about corruption in e.g. the police and public utilities are numerous, but this thesis is concerned with the implications of corruption for equity in health care. Two senior doctors employed by NGOs (TVO and Health Net International) interviewed in 2000/1 said they had left GOP service because of misuse of GOP property, especially in remote areas. They spoke of doctors who falsified purchasing and other records, and used BHU premises and equipment to practice privately. Both interviewees used the same phrase—*"I cannot work with these people"*. Misuse and diversion of premises, money and equipment to exclusively private practice results in the community having reduced access to the first level of the GOP system of health care—possibly none at all. Poor people will have the choice of either not using a

⁹ This school is an indigenous NGO to which VSO supplied two volunteer specialist teachers in the late 1980s and mid-1990s

¹⁰ The Centre resisted a move to treat women, although they were known to have suffered mine injuries.

service which has been transformed into a private one, because they cannot afford it; or if they do use it, they will have to pay for both consultation and medicines. Either alternative is inequitable, and traceable to inefficient management as well as to corruption. At the conference held in anticipation of the first phase of SAP/PDP, attended by a wide range of personnel, there was criticism of the example set by senior health professionals: "*students learn unpunctuality and lack of care from their professors*", one participant claimed. (GOP 1994: 2). This comment is more about laxity than about corruption, but a climate of laxity is likely to be tolerant of corruption. If staff work fewer hours than they are supposed to, patients' access to service is negatively affected.

NWFP : a special case within Pakistan— two population groups

The chapter so far has described the inefficient and inequitable social and health care climate of the host country, Pakistan. The amount of information available on Afghanistan limits analysis and makes it difficult to separate equity and efficiency, but as the health project's practice was for 13-14 years officially directed at Afghan refugees, it is appropriate to consider

- how far equity and efficiency featured in health care in Afghanistan before the Soviet invasion of 1979
- how far equity and efficiency were evident in the Refugee Health Programme in Pakistan

Health care in Afghanistan

Dr. Zamani and Dr. Wagma were able to quote their experience as former Afghan nationals¹¹ of provision in Afghanistan before the 1979 invasion. They considered that in Kabul and other major cities, health care was of a reasonable standard. Dr. Emel Khan remarked on the strictness of the system in Jalalabad where as a medical student in the 1970s he was refused certain pain-killers by a pharmacist who insisted on a prescription; he also remembered that a daughter of King Zahir Shah, a western-trained nurse, had no special privileges and worked regular shifts on the wards like all staff of a similar grade.

In the mountains and glens of rural Afghanistan, the story was different: a system of BHUs existed to provide first level care, but the more remote the area, the less likely to be adequately

¹¹ Dr. Zamani has acquired American citizenship, and Dr. Wagma became Pakistani on marriage; she started her career as a lecturer in Kabul medical school.

served. One refugee male patient at Gandaf camp claimed that he got the same injections for his children in Afghanistan¹² as he could at Gandaf HC, but Dr. Wagma thought this unlikely: she questioned standards of cleanliness and reliability of supplies in rural Afghanistan BHUs — *"sometimes they just use water for injections"*. The chapter on PHC mentioned efforts in remote areas of aiming for a small baby, and hopefully an easier birth, because of lack of skilled obstetric help. The Afghan MO at Shamsatoo camp BHU considered that the BHU where he had worked in his own country many years ago had functioned quite well, but he did not regard it as remote, being about 100km from Kabul.

It appears then that the urban/rural contrasts in efficiency and equity of health care applied in Afghanistan as they did in Pakistan.

The Refugee Health Programme

It is probable, once the camps were established and the Refugee Health Programme moved towards PHC, that most refugees in camps (not only camps served by ARC) had better access to health care than they had in the rural areas of Afghanistan from which most had come. The more numerous staff complement at Refugee Health Programme BHUs indicates the wider range and quality of services planned by the Programme (see Table 6.2). The BHUs are reasonably accessible to target populations, many being situated inside the camps. In some camps there may be several BHUs, some run by NGOs in partnership with the Programme. This was so within the very large Shamsatoo camp (pop. 70-80,000): there were five BHUs, two run by NGOs, the others directly managed by Programme staff. Programme BHUs had their own transport—*"very old vehicles needing a lot of maintenance"*, said the UNHCR Programme Officer (Health) in Islamabad. This reflected both the longevity of the Programme and the reduced finance as donor interest declined. Team establishment included a lady doctor, encouraging use by women. The Shamsatoo MO and LHV said staff leave was not a problem—*"senior staff can do everything"*.

In addition, the Refugee Health Programme, which like the GOP and ARC/PHC/FPHC systems did not offer 24/7 care, included a service aimed at compensating for limited hours (8am-2pm, 5-6 days per week) and was therefore pro-equity. The Programme included round-the-clock labour rooms, organised on the basis of one labour room serving several camps. Female staff included a peripatetic lady doctor. Further, in anticipation of births happening unexpectedly or where access to a labour room might be problematic, the Programme had developed a method of

¹² He said the family walked to the BHU—*"it only took a few hours."*

coping. The family could nominate a female member (usually mother-in-law) who received a delivery kit and some basic training.

While these arrangements should contribute to an equitable service, there was evidence from patients at Shamsatoo camp BHU¹³ that some inhibition persisted regarding female attendance at the BHU, but they could not estimate numbers. At this relatively new Programme BHU patterns of patient behaviour had perhaps not been established, but there was also some evidence of irregular supplies and variable staff attendance¹⁴. Wherever there is inefficiency of this kind, it affects service to patients of both sexes and all ages, and therefore equity, at least in the short term. One man in the male patient group at Shamsatoo BHU averred that

"we were healthier in Afghanistan, we were not so often ill—we had more to eat".¹⁵

There was some confirmation from elsewhere of variable standards within the Programme. Senior FPHC staff said that in-comers moving from other camps into the three ARC/PHC/FPHC camps because of job opportunities, security or family connections tended to have lower health status e.g. children might not have completed a course of vaccinations.

Yet in spite of possible variability in service and of uptake within the Refugee Health Programme, it is probable that in general camp-resident Afghans would have been exposed to a wider range of basic health care provisions in Pakistan via the Programme, and would have had easier access to them, than in their districts of origin. That is to say, the Programme was likely to be more efficient than the system in Afghanistan; equity is more likely to have been attempted, though unlikely to have been achieved.

Afghans who left Pakistan and returned to the homeland even before the fall of the Taliban in 2002 were at risk of experiencing lower or inconsistent standards of health care. Infrastructure in Afghanistan was severely damaged during many years of war and internal turmoil. According to the former Director of ACBAR at interview, for much of the 1980s and 1990s there was

*"a patchwork of health care and other work by NGOs in various localities within Afghanistan"*¹⁶.

¹³ There was no labour room at this particular BHU but in such a large camp it is probable that there was at least one.

¹⁴ On the day of my (unannounced) visit some staff arrived late; all left early; the pharmacist said they did run out of medicines from time to time.

¹⁵ Shamsatoo camp re-opened to cope with the "drought" refugees of 1990/2000; UNHCR arranged distribution of rations because of their poor nutritional state. Ration issue had ceased long ago in the old camps. This man was a long-stay refugee who had entered Shamsatoo from another camp, perhaps attracted by the rations. His recollections of Afghanistan referred to many years previously.

¹⁶ Godfrey (1993: 333,372,382-385) lists one health-oriented NGO working cross-border in 1984, 17 in 1985 and 41 in 1989, mostly from bases in Peshawar. See Chapter 5 for lists..

For most years of disruption there were areas which remained fairly peaceful, but Government, fluctuating as it was, was in no position to organise universal health care, leaving the field open for NGOs. Since the fall of the Taliban and subsequent military action, there has been further devastation. President Karzai continued to make appeals for international help (BBC News 6/08/03). UNHCR's policy was to issue basic equipment and a small cash allowance as inducements to Afghans to go back to their own country, but the return rate of 100,000 per annum to Afghanistan has been offset by the high birth-rate, according to senior UNHCR staff in Peshawar (interviewed 2001). They considered that the refugee population in NWFP had remained virtually constant at 2 million since 1992, when the fall of the Najibullah government sparked off a major exodus from Pakistan back to Afghanistan. Numbers are not available, but some who went back to Afghanistan re-entered Pakistan. Life in a refugee camp was apparently preferable to conditions in Afghanistan. Access to health care was possibly a factor in their decision.

ARC/PHC and equity

The circumstances of rural NWFP, where there are two distinct populations, refugees and local Pakistanis, have a bearing on the equity principle. In terms of socio-economics and health, the problems of both groups were similar, but officially separate health care systems ran in parallel for over twenty years within the host country. Zia Rizvi warned during his compilation of the External Evaluation of 1993/94 of ARC/PHC's potential isolation, because of its greater efficiency and effectiveness: inequity between ARC/PHC's service and GOP's system was likely to continue or even increase.

He made the comment at a time when the health project had matured into something much more wide-ranging and reliable than GOP's service to local people. However, equity between refugees and local Pakistanis seems to have been considered as a policy even in the early days of the Programme, when senior officials decided to allow villagers to access camp services and amenities (GOP 1984 ch.14, para 13). GOP's motivation may have been political, in anticipation of disagreements and outbreaks of violence, if locals perceived refugees as unduly privileged. GOP was probably also thinking short-term, since the expectation was that the refugees would soon go back to Afghanistan. Senior staff at the UNHCR Office in Peshawar (who tend to do relatively short tours in any one post) seemed unaware that a formal arrangement had ever been made, but they conceded that the principle of access by local people had long been generally

accepted (though never formalised) throughout UNHCR, wherever it was active, not only in Pakistan. One staff member recalled at interview in 2001 that when he had worked in Uganda, the Health Minister had told him of his pleasure whenever he saw a UNHCR-sponsored refugee health unit sited at a roadside, because this enabled use by local Ugandan people. Such casual—indeed chance—instances of equity, even if helpful to some people in need, reduce pressure on governments to fulfil obligations, let Ministries off the hook by diverting cash elsewhere, and are not human-rights-based.

It is difficult to assess how far the equity principle motivated either the Austrian donors in transforming ARC/PHC into a new NGO, or GOP at the time of SAP/PDP Phase 1. The SAP/PDP Assessors saw the health project as a resource of potential benefit to local people at their visit in 1995. In 1993/94 the Austrians recognised the health project as exemplifying effective overseas aid, with a development potential—and maybe all that could be salvaged from the demise of ARC. The small indigenous senior management group of the health project (at that time there was no local Board of Governors) who were mostly Pakistanis had already been sufficiently concerned to discuss contingency plans for the residual nucleus of human and material resources. If ARC were to move all projects into Afghanistan, as was its plan in 1992/93, when it was primarily concerned with Afghans, buildings would crumble, skills wither, and several thousand local Pakistanis would lose the service they had actively sought. Senior health project staff had no great faith in the future if assets were transferred to GOP. It was the sudden death of Dr. Janata in 1993, Chairman and inspiration of ARC, which put a stop to transfer into Afghanistan. This triggered action in Vienna leading to the first External Evaluation and eventually the formulation of plans for the health project—in effect a pro-equity future.

Some of what has been said above about the Refugee Health Programme service to Afghans applies to ARC/PHC in its early stages. Adopting and practising PHC was fundamental to the aim of equitable provision for the target population, energetically promoted by Dr. Zamani. Access was unlikely to have been universal when mobile vans were used, and building trust with the community to encourage use was a long process. I have already referred to Zia Rizvi's comment about the 5-6 years it took before a satisfactory attendance by women was attained (80-85%). But all care to the people in the three camps was free, as it was throughout the Refugee Health Programme.

During these ARC/PHC days, some additional practical benefits for patients attempted to combat poverty as well as being intended as inducements to attend the ARC BHUs. New mothers and babies received soap and suits of clothes, and once a year volunteer health workers

were given suit-lengths of cloth or plastic sandals. These hand-outs may be criticised as encouraging dependency, and I did hear comments from some patient groups in 2001 that ARC was more generous than FPHC: these were camp residents, not villagers. It was the secure regular income from Austria in ARC years which enabled these gestures at the health project.

FPHC and equity

in general

Participation was consciously studied and actively promoted at FPHC especially after the 1995 watershed. Equity, the third “pillar” was not discussed as a concept at FPHC in the way that participation was, nor was there conscious recognition of it as there was of collaboration, so that it is not really possible to say that there was a FPHC “definition” of equity. Senior staff said that UNHCR turned a blind eye if any surplus of medicines intended for refugees was used for local villagers, which fits with the informal understanding throughout UNHCR.¹⁷ The movement of health care work into the villages, whatever the impetus, was in essence equitable, since it attempted to be non-discriminatory. In spite of apparent eagerness of these local communities to approach FPHC, in practice, up-take of service by villagers was slow and gradual, as indicated elsewhere in the case study. This appears related to an on-going need for health education—communities took a long time to understand the different preventive and health promotive thrust of PHC as distinct from the curative practice they were used to—and was what they had actually got from the health project until the change in policy made all programmes available to them. Precise figures for non-users of FPHC services from either villages or camps—for whatever reason—were not available.

The movement into the villages however is a macro-approach to equity. It is possible to make a more micro-assessment of FPHC’s understanding and attempts to practise equity.

more specifically

Although the abstract concept “equity” was not articulated, FPHC staff as practitioners close to the client group appreciated that disadvantage existed. There were long-standing practices and innovations where efforts at equity were implicit. There were also some failures in attempts to add pro-equity initiatives.

¹⁷ Perhaps this is an example of inefficiency (i.e. a surfeit of supplies) contributing to equity.

Pro-equity activities at FPHC:

- **“poor” lists:** widows, families with a handicapped member or where no-one was in work were excused the Rs 10 Health Centre admission charge. These lists dated from ARC/PHC times and were confined to camp residents, except for Kagan village, where there was much local inter-marriage and a high incidence of handicap. Staff said communities reported changes in family circumstances, thus monitoring additions or subtractions.
- **employing disabled/disadvantaged people:** one of the clerical staff in the FPHC office had a crippled leg (not a war wound); a woman whose husband lost a leg fighting in Afghanistan was engaged as a trainee LHV and worked at FPHC for some years; a teenage teaching assistant at the girls’ class at Gandaf was the only cash earner in her family.
- **patients with a chronic condition** (implying frequent HC visits/charges) were issued with a longer-term supply of medicines
- **stress on MCH care** before/during/after delivery, and issuing delivery kits to nominated family members, as in the Refugee Health Programme
- **promotion of family planning: use of counselling and involving husbands.** The MCH/FP policies had been emphasised since ARC/PHC times, but involving husbands was intended to reduce the burden of responsibility on women. On weekly Outreach Days, staff duties included seeking out patients (especially women) more distant from the Health Centres, and also defaulters in any programme.
- **setting up a local branch clinic for women** living on the outskirts of Ismaila, a large and widespread village (pop. 20,000). This twice-monthly clinic was instituted by one of FPHC’s lady doctors, concerned that more distant women found it difficult to access the Health Centre. Dr. Wagma said that this staff member, employed at FPHC for some years, had been converted to PHC from her original curative bias and rather inconsiderate attitude to patients.
- **gender training:** FPHC introduced gender training in the later 1990s at the insistence of CIDA, but in 2000 the training was still restricted to staff. FPHC staff recollected initial efforts by CIDA to provide this training via its own Pakistani staff as confrontational.

After Dr. Wagma had herself been trained as a trainer by CIDA, it became more acceptable, but at interview some senior male staff were still self-conscious about it.

- **female/male staff ratio** and opportunities for female staff: in ARC/PHC days, all three FPHC Team Leaders (doctors) were men, but the Annual Report of FPHC for year 2000 (p ii) records that three out of seven Team Leaders in post that year were women. The female senior staff group (which included LHVs and trainers as well as doctors) believed themselves influential within FPHC. Mobility of female staff had increased by year 2000 sufficiently for some to attend occasional courses in Peshawar and Islamabad with a male escort and/or in groups, provided accommodation was arranged in advance. Dr. Emel Khan observed that in recent years there was generally less veiling.

Less successful attempts at equity

In the late 1990s FPHC drew up two proposals:

- a pre-school education project; also intended to stimulate women's interest in education and possibly train some as classroom assistants. The potential donor delayed consideration of the proposal and eventually rejected it.
- FPHC obtained funding for a mental health project, but the VSO volunteer placed to manage this in 1996 had to return to the UK after about six months and the project fell.

If either of these had got under way, they would have been pioneering exercises. While the mental health proposal was being contemplated, and communities were being asked for suggestions, a few families produced mentally handicapped members—not mentally ill—but it was not possible to devise a specific plan of action. In one camp, two resident men ran a small play group for about 10 mentally handicapped children. The men had received a few days' training from SCF; resources consisted of a room and a small box of toys. The indications were that there had been some improvement in the children's behaviour, and no doubt some relief for the few families who brought them. This exercise was quite independent of FPHC.

Equity and efficiency at FPHC

The chapter has indicated the difficulty of separating equity and efficiency, particularly in a case study of a practitioner organisation. However, one of a collection of papers (Nabarro and Cassels 1994) on strengthening health management capacity in developing countries specifically addresses efficiency by arguing that resources must be better managed in order to ensure the greatest possible benefit to those who need care, that is, in the interests of equity. The pro-equity

activities at FPHC listed above derive from policy decisions: implementation of decisions depends on efficient and effective management, percolating through all grades of staff.

Nabarro's four broad headings of the universal problems of management are negative in tone, but are useful in assessing evidence from fieldwork concerning the equity principle as it could be identified in health care as practised in NWFP, including FPHC. More detailed evidence has been quoted already in the chapters on participation and inter-sectoral collaboration, serving to emphasise the mutually reinforcing relationship between all "Three Pillars".

Nabarro and Cassel's "universal problems of management"

1. Inefficient use of resources:
2. Inaccessibility
3. Poor response to demand
4. Costs—to the organisation; to the patient (1994: 5)

The thesis has several times quoted fieldwork and other evidence demonstrating GOP's failure to provide an effective service. Nabarro's headings show that problems of management in GOP's service are fundamental to its inequity. Centralisation, compartmentalisation, over-burdening of middle-management, persistence of inadequate service-delivery to remote areas, and a limited range of services at basic level with added costs to patients must rebound on the poor, and especially the poorest.

Yet within the GOP system, there were individual instances of efforts by managers (at least at BHIU level) to counter these problems and aim at some degree of equity. The new MO at the Charsadda BHU attributed the dramatic increase in patient attendance between 1998 and 2001 to his regular daily attendance. This BHU was actually situated in the middle of a graveyard¹⁸.

At the Swabi BHU, the MO said he had a plan for coping with unreliable drug supplies. He had devised a form of rationing: he asked individual patients if they could afford to buy prescribed drugs in the bazaar. Thus he managed to retain a cache of medicines for those who could not afford to pay. He said he was confident of identifying poor people because "*I know them, I have been in this job (i.e. at this BHU) for seven years*". The female patient group at this BHU did not consider themselves to be poor—nor rich either—and were all of good appearance. The usual period of service for an MO at any one BHU is 2-3 years. My interpreter thought that the local

¹⁸ The Health Minister (who knew of this BHU but had not visited) thought that this siting was a disincentive, but it appeared that it did not deter patients, who responded in increased numbers to the conscientious work of a relatively new MO.

khan (present as a patient) would have been influential in retaining a doctor he rated as effective. This MO's practice of training and supervising local TBAs and creating a "clean room" for deliveries at his BHU also represent efforts at efficient management and consequent equity. This BHU had the highest number of attenders at any BHU or Health Centre that I visited (75 on the previous day). At middle management level, the EDO (Health) in Charsadda District disregarded his official visiting schedule and took to dropping in unannounced to BHUs, in an attempt to curb staff absenteeism. Even in the relatively compact and densely populated Charsadda District with no mountainous or difficult terrain rendering supervision extra burdensome, he did not think his technique very successful—*"it can go back in a week"*, he said.

Nabarro and Cassel's categories applied to FPHC

1. Use of resources

- As an NGO, FPHC had control of its material resources and its disbursements; it was not confined by the departmentalism and fragmentation characteristic of GOP's system.
- FPHC arranged repair of buildings, servicing and replacing equipment (including office equipment) as necessary—subject to the vagaries of agencies contacted, which might be in Peshawar or Islamabad rather than Mardan.
- FPHC purchased directly from pharmaceutical agencies if there was risk of medicines running out.
- Registrars (clerks) at each FPHC Health Centre carried a small float for minor purchases and for inducement payments to FHWS who were entitled to claim for bringing women for three ante-natal visits. Claims had to be verified from records and payment authorised by senior staff. Registrars also co-ordinated monthly quantitative data to the FPHC office. Neither GOP nor Refugee Programme BHUs had an equivalent post.
- Each FPHC Health Centre had its own vehicle and driver for transporting staff and patients to hospitals, collecting and delivering supplies, and for outreach work (again, mostly old vehicles, mostly inherited from ARC, originally donated by UNHCR). Drivers and vehicles could be deployed flexibly as needed. In 2000, the total FPHC fleet was eight vehicles including one hatchback car, two pick-ups and several land cruisers.

- Staff had to sign a daily attendance register; unauthorised absence was reported and punished by a fine or reduced leave (Conditions of Service 1995). There was also a system of verbal/written warnings.
- Salaries were comparable with GOP rates, but lower than in ARC/PHC times. In my experience, they were invariably paid on time. Contracts were annual; there were no pensions, but arrangements existed for severance pay linked to grade and length of service (less generous than in the ARC/PHC era).
- FPHC rented two houses, one in Mardan and one near Gandaf for staff who did not live locally, but returned home at weekends. Transport to and from staff houses was by FPHC vehicles.
- FPHC maximised human resources by training people in more than one discipline, e.g. a vaccinator was capable of working as a malaria supervisor or a nursing assistant, so as to compensate for absence on leave or attending a course. Long-service contributed to staff adaptability. FPHC sent staff to courses provided by other agencies; staff also attended in-service and refresher courses set up by HRD Unit of FPHC itself.

Dr. Zamani established a tradition of accurate recording and rigorous staff supervision, himself setting a personal example of dedicated hard work. We observed these patterns when we arrived in NWFP in 1991, and in my opinion there has been very little relaxation of them. Supervision and control of office and team staff (and of all resources) was more achievable in the relatively small and localised ARC/PHC/FPHC organisation than in either of the other two large agencies.

The obverse of these attempts at good management practice is that once FPHC became an independent NGO it had no guarantee of security and sustainability, and had to pursue sources of finance intensively and persistently. It is not unusual for NGOs to operate in an insecure financial climate (nor is this so only in developing countries). For FPHC, reduced income would inevitably mean reduced service either by omitting one or more programmes, or by closing a Health Centre and terminating (*sic*—i.e. dismissing) some staff, all with consequences for equity. However, FPHC management exhibited foresight by drawing up formal plans. When FPHC submitted a proposal to CIDA for the year following, the Women In Development Co-ordinator at CIDA expressed surprise at its ability to plan so far ahead:

“because we are in contact with NGOs which cannot pay their staff for the current month” (conversation at CIDA Office 1996).

2. Accessibility

The three older Health Centres were reasonably sited for access, each being adjacent to its camp, but staff accepted that even in these middle-sized camps (compared with some other camps) attendance was inclined to be greater by people within easy walking distance. Baghicha village women felt themselves disadvantaged by being further from the Health Centre than Baghicha camp residents and wanted FPHC to provide transport. Interview evidence from all the women patient groups indicated some persisting inhibition of female attendance, more so in the newer or more distant Health Centres. The female patient group at Gandaf camp knew of a husband who bought "*injectibles*" at the bazaar which they believed he administered to his wife who had three children, but they could not say whether these were contraceptives or abortifacients. Whatever they were, she was being denied access to proper advice.¹⁹

The behaviour of the Kagan villagers as the first local community to seek treatment from ARC/PHC bears out the comment by the UNHCR staff member from his Uganda experience, for the Kagan Health Centre is immediately across the road from Kagan village. Any local potential to pressurise GOP to improve its own service has thus been reduced; but I found no evidence of villagers trying to pressurise any Department until, as at Wardaga, they had come together as a formal CBO. Although village patient groups expressed dissatisfaction with GOP services, they seemed resigned to low standards about which they did nothing except make ineffectual complaints—or they took their custom elsewhere, including to FPHC. This community inertia seemed especially evident at Baghicha village, where people expected external agents (*khans* and FPHC) to take action on amenities and transport.

The 1993/94 Evaluation noted that the health project attracted people from outside its target area, some of whom had travelled considerable distances (20 kms, 1994: 32). This persisting trend was reported in year 2000, but no figures were kept for these "guest" attendances. "Guests" had to pay for what they received.

3. Response to demand

Chapter 6 gave some examples of patients finding ways of communicating dissatisfaction, which Dr. Emel Khan saw as evidence of the community's positive interaction with FPHC. I was aware that FPHC patients might present an uncritical image of the NGO to me, because many

¹⁹ The group suggested two ways of tackling this: a) the patient should come to the HC without telling her husband or b) a CHW should talk to the husband—they knew of a case where this had been effective.

already knew me, and because the culture demands that they treat a guest with courtesy, i.e. they try to say what the guest would like to hear. In spite of my urging them to talk *speen* (white, or sincere, truthful) I did not uncover any evidence from patients of FPHC staff being rude or uncaring, indeed some village groups remarked on the considerate attitudes of FPHC staff.²⁰ But the dismissive attitude of male staff at Gandaf Health Centre who perceived the camp women as incapable of running groups because they were illiterate probably inhibited the women's avowed willingness to participate in group activities: a potential resource seems to have been under-used. Gender prejudice appeared to have persisted within this group of staff.

Most village patient groups said that "*rich people*" whom they said were lawyers, teachers and landlords did not use the BHUs (the Swabi BHU being an exception), but staff said that at FPHC's Wardaga HC it was not only poorer villagers who attended. When the better-off began to understand the range and purpose of care (even the relatively restricted MCH-only service at Wardaga) they attended, in spite of rather snobbish and superior attitudes, shown by their reluctance to queue. "Health for All" implies that understanding the nature of PHC will encourage participation and equity: if the rich are biased towards curative medicine, they need some health education. Wardaga being the home village of Dr. Emel Khan and Dr. Wagma, their presence may have influenced a positive view of the kind of health care being promoted there by the local FPHC staff team, although neither Dr. Emel nor Dr. Wagma. worked in the team.

4. Costs—to the organisation and to the patient

Diskett and Nickson introduce their discussion of funding PHC by declaring that costs of implementation had been underestimated, and that many countries would be unlikely to find enough public money to meet all demands for health services. The ideological conflict between "Health for All" and fiscal and organisational problems encouraged interest in charging for services by governments and by NGOs as well (1997: 73). Among refugee-oriented NGOs, ARC/PHC had the reputation of being quite wealthy. It had for many years a regular assured income from a d c Austria, requiring only annual reporting and a formal proposal (including audited accounts). Transition to indigenous status raised awareness of financial aspects.

Costs to the organisation

FPHC was heavily donor-dependent in terms both of finance and material provision such as drugs. When the health project served refugees only, not only did it provide all health care free, but it distributed handouts as described above. The 1995 changes meant that handouts were not

²⁰ Senior staff had worried about the attitude of one Afghan LHV to village women; she left in 1998.

justified for local Pakistanis, so refugees also ceased to receive them. This was the point at which a small charge was introduced. Camp residents appear to have accepted these changes, following discussions between FPHC and elders. This smooth transition must owe something to Dr. Emel's inter-personal skills. Staff and camp residents also realised that as a result of the break-up of ARC, the health project had been at risk of disappearing completely.

It was however difficult to assess real organisational costs:

"Total gross cost of organisation in 1994 (i.e. ARC/PHC, officially serving refugees only at this date) divided by number of people registered gives an expenditure of Rs182 per person in the population served. It is not practicable to cost every kind of activity separately: it is particularly difficult to cost the large amount of staff time used in the prevention of disease via health education. One attendance at a BHU can include several items such as examination by the doctor, lab. examination, supply of medicine, plus health education. Adding BHU attendances and home visits together, the cost of one episode of consultation between a patient and one or more members of staff in 1994 was Rs 50.

Some malaria and other drugs are supplied by GOP and UNHCR according to the list of generic drugs. Costs of drugs are kept low by adhering to agreed guidelines and also by successfully educating patients over many years not to expect injections/drugs for every condition. Cost of drugs and dressings in 1994 was about Rs 20 for each person registered" (1994: Application to SAP/PDP Phase I: 12)²¹

The Application also points out that the Director worked voluntarily on Saturdays, equivalent to a donation of about Rs 30,000 per annum, and estimates the value of time and labour of CHWs and TBAs (250 expected by mid-1995) at Rs 1 million (1994:13). The income for 1994 from all sources according to the audited statement was Rs 7,639,775 and expenditure was Rs 6,715,222 (ARC/PHC Annual Report 1994: 41). Obviously resources were subsidised by voluntary activity. Without it organisational costs would have been much greater, so that it could claim that it gave value for money. In later years, an increased patient contribution augmented income. There is no possibility of cash contributions from poor people enabling organisational self-sufficiency (Diskett and Nickson 1997: 4) but comparable figures for year 2000 were Rs 14,662,978 (income) and Rs 9,421,716 (Annex B of FPHC Annual Report 2000), indicating a healthy surplus of over Rs 5 million for that year. But such relative security cannot be presumed as continuing, given the precarious nature of NGO financial status. Matthias and Green point out that NGOs are able to control their expenditure, but they have little direct control over their income, dependent as many are on external donors (1997: 146)

²¹ This extract from the Application was written by JSP in his capacity as voluntary Development Adviser.

Costs to the patient

Non-discrimination meant that the charge applied to refugees as well as to villagers. FPHC introduced a charge of Rs 5 per head for each visit to a Health Centre, later raised to Rs 10, collected by the Team Registrar—administratively simple and psychologically sound. All standard basic programmes of EPI, health education, ante-natal and delivery, etc. were free, but FPHC charged for the extra of pregnancy testing (Rs 40, less than at a private agency) and started an experimental medicine bank at Wardaga. Senior staff considered this experiment not very successful, because patients tended to patronise one of several easily accessible private dispensaries in the village; they said medicines there were attractively packed.

Problems with charges

However, charging is fraught with problems. At patient level, both refugees and villagers, it seemed to be acceptable on grounds of value for money—all patient groups agreed that you got a lot from FPHC for your Rs 10. One woman in the Wardaga village patient group said the charge should be more—“*because this is private*”. But willingness to pay is not the same as ability to pay. For poor people, Rs 10 is a lot, and several people said that borrowing from relatives went on (though no-one actually admitted to it themselves). They realised that attendance at FPHC required less borrowing.

Baghicha village men claimed that poor people need not be deprived of health care from any agency for lack of money, because it is a religious duty to help those in need. They said that people would only have to ask or beg, and others would respond. Probably this had helped to alleviate problems of travel costs and of medicines when they were not available from GOP BHUs, but perhaps not everyone is willing to ask or beg, particularly in the face of recurring need, nor can it be assumed that everyone will respond positively. But health care dependent on charity from individuals to individuals is not health and health care as a human right; nor is charity likely to be effective on a national scale: “*charitable giving is not the answer to structural poverty*” (Clark 1991: 117; see also Zaidi 1988: 119). The first Chairman of FPHC’s Board of Governors concurred, declaring that irregular donations of around Rs 500 were as much as might be expected from the Mardan elite.²²

²² As respected Headmaster of a new local boarding-school organised on British public school lines, dependent on parental fees and voluntary subscriptions, Abdul Ali Khan said he had difficulty in raising adequate income; he said people contributed only when ordered to by GOP.

This emphasises that underlying inequity in health and health care is the much wider and more fundamental question of in-country social inequity, posited by Townsend and Davidson and evident in a more extreme form within many developing countries including Pakistan. The causes of structural poverty ramify into global and national trade and economics policies, including the exploitation of the “South” developing world by the countries of the developed “North”, much written about by others, and I do not intend to dwell on it here. What is clear from the literature is that the effects of policies promoted by the World Bank and the International Monetary Fund rebounded on the poorest:

“Evidence indicated that between 1987/8 and the early 1990s, the period coinciding with the intensification of structural adjustment in Pakistan, poverty increased and income distribution worsened “ (Khan 1999: 7)

“Although there is statistical evidence that absolute poverty in the country has declined, income inequality has increased—inflation in 1996 was believed by many to be as high as 20%...the inflationary impact has naturally fallen on the least well-off sectors of society” (Weinbaum 1999: 99).

“User charges ...tend to be regressive—because the sick are penalised in relation to those enjoying good health...Moreover, the poor pay more, because they are at greater risk of being sick” (Diskett and Nickson 1997: 75)

This last however presumes a system where the poor pay for curative care, with consequent inequity. The FPHC patient contribution, a payment per capita per HC visit, amounts to a flat rate admission charge: thereafter all patients have access to all services, preventive and curative.

Charging for primary health care: other criticisms

Apart from the practical problem for the patient of finding cash, charging raises serious questions of principle. David Werner, for many years committed to the Alma Ata aim of “Health for All” sees the pressure to make disadvantaged people in poor countries pay for health services as a major set-back. He identifies the following problems:

- cost recovery reduces utilisation of services by high risk groups
- money for food may be diverted to paying for medicines
- charging for medicines may encourage over-prescribing
- safety nets (very poor/handicapped lists) work better on paper than in practice
- misrepresentation: cost recovery as self-reliance/community participation

“When a health system begins to saddle the poor with the burden of its costs, this is a great step backwards. It means that health care is no longer a basic right” (1993: 5).

Matthias and Green suggest a potentially positive aspect of user charges: they may promote greater responsiveness of the provider to the wants of the user. But they also warn that there is a difference between *wants* of the user and *needs of a whole community*; in other words, this change in relationship may pose an additional threat to the social objective of equity (1997: 128).

Werner's paper cites UNICEF and the Bamako Initiative (payment for essential drugs) as an example of shifting charges to the poor, and suggests that cost-recovery is a new version of selectivity. He is however relatively optimistic about grassroots efforts at Primary Health Care, seeing them as contributing in the long run to far-reaching social change in keeping with the aim of "Health for All": "*The struggle for health is the struggle for social justice*" (Werner 1993: 9). That is a long-distance view: financing a functioning PHC service is an immediate concern.

Financing primary health care: reality

Writers on health care finance quoted below accept the principle of "Health for All", but struggle with a number of ways of funding PHC. Carrin and Vereecke address national measures such as re-allocation of resources to basic care, raising taxes and introducing insurance schemes (1992: 32, 33, 38) but none of these is practicable throughout Pakistan. I have already referred to GOP's budgetary choices, its departmentalism and corruption, which would most likely be exacerbated by the required additional administrative structures. Such measures are not appropriate for FPHC, a local NGO. Carrin and Vereecke also consider various methods of community financing, assuming that the principle of free health care has to be modified, such as paying for medicines, or fee for service, or some form of pre-payment, all or any of which are apparently feasible methods for an NGO (1992: Preface).

Abel-Smith (1994) presents arguments in favour of user charges as follows

- they are likely to reduce frivolous use of a service
- people are paying something anyway, if using private medicine and/or travelling some distance for health care
- it makes economic sense—marginal cost
- the money can go towards improvements in the service (1994: 167)

He admits that managing exemptions for the poor is problematic, but suggests that organisations with long-serving staff (as FPHC is) know their communities very well (1994: 169). He notes

possible disadvantage to women, who have no control over household budgets—and women and children are the greatest users of health services (1994: 170). He also comments on the lack of administrative capacity in developing countries, affecting implementation of any scheme. But in the end he decides

"it is more equitable to charge than not to charge, i.e. if poor services drive people to the private sector—assuming that payment improves or sustains a "better" service" (1994: 176)

The second and fourth of Abel-Smith's favourable arguments are particularly relevant to FPHC. I have already referred to attendance by "guests" attending ARC/PHC/ FPHC, in spite of having to travel some distance. Team Registrars are administratively competent, and experienced since 1995 in collecting the Rs 10 contribution. This money is banked to accumulate as a reserve, and in 2004, as another financial crisis (hopefully temporary) has arisen, is being used to supplement income and sustain the service.²³ However, it is not clear whether introducing charges at FPHC has reduced utilisation by high-risk groups or by the very poorest—probably a detailed survey would be needed to ascertain this.

While cost-recovery may well prejudice the concept of health as basic human right, donors are much in favour of it.

Donors, charges and equity

During the transition and reconstruction period of 1993-1995, the phased withdrawal of funding from a d c Austria meant that new donors had to be found. The response by some prospective donors suggested that FPHC was at risk of falling between two stools:

"TVO (Trust for Voluntary Organisations) in Islamabad was an obvious possible donor, because of its aim to foster development projects through its financial resources—but for the benefit of Pakistani nationals only, not for refugee Afghans"

"Afghan-focussed agencies' policies did not allow them to support an NGO caring for local Pakistanis" (MMP Final Report to a d c Austria, October 1998: 6)

Neither Pakistani nor Afghan-focussed agencies (some by this time restricting their activities to Afghans inside Afghanistan, instead of refugees) would consider an NGO with a new non-discriminatory policy, although public health is in the interests of all whatever their nationality, and in agreement with the principle of health for all as a human right. There might have been an

²³ Communication from Director FPHC 5.11.04

opportunity for a fresh donor approach to equity, when some might have taken a wider and more pragmatic view, treating refugees and indigenous rural poor as people with the same human needs and rights. But these donors would have had to ignore the boundaries of their remits; or if they were to re-negotiate remits either internally or in collaboratively, the process would have taken a long time, with many political overtones, not least the debate between aid and development. FPHC's target became the securing of income from any available source in the interests of survival:

" it became a matter of finding money from somewhere, anywhere, to keep FPHC going " (MMP: Final Report to a d c Austria 1998: 7).

This was effected after much hard work, but FPHC had entered a competitive market and faced the continuing problem of the pursuit of adequate income.

Conclusion

Within NWFP, the three services discussed in this thesis all aim to provide comprehensive first level care, but as none provides a full 24-hour 7-day service they are all lacking in one dimension of equity.

In spite of its initial minimal cost to patients (sometimes not levied at all) factors detailed in earlier chapters and summarised in Nabarro and Cassel's categorisation of management problems, the GOP system was neither efficient nor equitable. The restricted range of the service meant additional costs for the patient, especially the poorest, a further threat to equity. The position of women and girls in the Pathan society of NWFP is essentially inequitable—probably more threatened in NWFP with its strict adherence to *purdah* than in some other communities in Pakistan.

The Afghan Refugee Health Programme was more equitable in design than the GOP system, and, for its target population, more efficient in practice. It was probably more efficient and equitable than what existed in rural areas of Afghanistan before 1980, or what the Afghans were likely to experience as returnees to Afghanistan. An appropriate staff complement with transport support aimed at free delivery of a wide range of PHC programmes. The Programme took account of women's and infants' needs by employing lady doctors, and providing the specialist facility of 24-hour labour rooms. But fieldwork evidence hinted at familiar problems of shortages and staff absenteeism, some probably traceable to bureaucratic inefficiency.

FPHC had a positive approach to equity from its early ARC/PHC years, as outlined in previous chapters on participation and inter-sectoral collaboration, even if these had for a variety of reasons not been fully realised. A wide range of PHC programmes, greater accessibility and reliability because of better control of resources, mostly viewed positively by refugees and non-refugee patients, added up to a more efficient and equitable service for its target populations than those of the other two larger systems. But by introducing user charges, FPHC may have compromised its position on equity. In this it is reacting to the typical chronic problems of insecurity and financial sustainability of NGOs, and the attitudes of donors who decry what they label as dependency and insist that people value what they have to pay for more than what they get for free. These attitudes disregard the question of ability to pay and health and health care for all as a human right. For NGOs, tensions between the target of equity and the ongoing need to find income from donors who support cost-recovery are likely to continue.

The problem of social inequity both within and between nations underlies that of inequity in health and health care. However this is not an argument for not aiming at equity in health care: equity is an ideal. Achieving total equity is perhaps as much of an illusion as achieving total objectivity, a topic addressed in chapter 2, but similarly is also a goal to strive for, and as Carr-Hill says

*“equity in the context of a discussion of health care systems is about **pursuing** a fair distribution of health rather than **attempting to achieve** a fair distribution of health”* (1994: 1190)

The pursuit of a fair distribution of health is the topic of the next chapter which will assess FPHC's impact on the health of its target populations.

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CHAPTER 9

FPHC's IMPACT ON HEALTH

The previous three chapters assessed how far FPHC had progressed in its understanding and implementation of the "Three Pillars" of PHC. The chapters also explored how far the concepts were evident in the basic health care services for the two populations in NWFP, refugees and non-refugees.

Using the four-phase timetable of ARC/PHC/FPHC's development as far as possible this chapter aims to assess the effect the NGO had on the health status of its target populations—the original refugee group in the three camps of Gandaf, Baghicha and Kagan, and the later additional patient population from Pakistani villages. This requires the use of fieldwork material, mostly qualitative, concerning operational aspects of primary health care.

Assessment also requires quantitative data. I have chosen to restrict this mainly to Mother and Child Health and Family Planning; as explained later, the chapter deals with Family Planning as a separate topic. This chapter also attempts to relate FPHC data to similar data, qualitative and quantitative, for the general refugee and Pakistani populations, as far as such data are available, in order to provide some context.

SECTION A considers the qualitative approach to assessing impact, for impact is not only about figures. This is especially so for a case study concerned with the radical strategy of health care promoted by the Declaration of Alma Ata. The Declaration's definition of health is a more positive, comprehensive and people-centred one than merely the absence of disease or infirmity.

SECTION B of the chapter considers quantitative data.

SECTION C considers Family Planning data.

SECTION A: QUALITATIVE DATA

Oakley, Pratt and Clayton introduce their discussion on evaluating outcomes and impact of changes brought about by social development programmes and projects by stating that there has been

“a steady and noticeable increase in the practice and development of more qualitative approaches to monitoring and evaluation” (1998: 47)

Assuming that basic health care is a fundamental component of social development, the statement supports the validity of a qualitative approach to assessing a health project. However, data gathered by qualitative methods need a framework for analysis. There are two options:

Option 1: One way of assessing such data as an indicator of effect and impact would be to locate the most up-to-date framework and apply it with hindsight to the twenty-year period of the study. This would have the advantage of precision because of lessons learned and resulting refinement in test situations in various countries. However, this approach might be overly sophisticated, given that the early ARC/PHC years (and the Refugee Health Programme as a whole) followed fairly soon after the 1978 Declaration of Alma Ata. These years were marked by struggles to respond to huge practical needs. A detailed and theoretical analysis might not be appropriate or possible, depending on what might have been recorded—or quite probably not recorded. Chapter 3 explained how WHO advisers promoted the PHC strategy at the Refugee Health Programme, and made training available to encourage partner NGOs to attempt it. In spite of the unremitting large-scale practical problems of service-delivery, some organisations and individuals did aspire to understand and implement the new ideas.

Option 2: Another option is to use a framework which is both local and contemporary with some of the years of the health project. This is provided by Ajmal’s report of 1989 for SCF (UK). Chapter 3 explained the role of Save the Children (UK) in the 1983 introduction of CHW training as part of the Refugee Health Programme’s move from curative to public health focus. Setting up fixed BHU stations with small teams of qualified health staff¹ instead of a mobile service was only a partial improvement. It was not possible to reach every doorstep without seeking help from the community itself, that is, volunteers who could be trained as health workers. SCF (UK) started a scheme to train CHWs at one camp in NWFP where they already managed a clinic, subsequently setting up courses open to interested organisations, including ARC.

In 1989, a member of SCF’s staff, Dr. Waqar Ajmal, produced a report on the 6-7 years of the original CHW scheme, including an assessment of its impact on that part of the refugee population who first experienced it. Impact of an initiative is not necessarily the same as success, but to talk of “success” appears justifiable in this case because of the considerable

¹ In 1983 each Refugee Health Programme fixed BHU (one per 15,000 population) was staffed by a team comprising LHV, Dispenser, Vaccinator, Malaria Supervisor/Sanitarian, Midwife, led by a MO (Ajmal 1989:3).

penetration of volunteer workers into the Refugee Health Programme, so that CHWs and TBAs became essential to the Programme's practice of PHC. Ajmal treats the introduction of CHWs as fundamental to primary health care, indeed virtually synonymous with it.

A basic Refugee Health Programme however was in place before CHWs were introduced, effectively as complementary to it. Ajmal's headings lend themselves to an assessment of the impact of primary health care beyond the use of CHWs—or the impact of a primary health care programme which incorporates CHWS.

Introducing his framework, Ajmal acknowledges that a primary health care programme takes time to show impact. He postulates that

"the indicators of success (i.e. of impact) are different at different stages of the programme"

and lists his indicators in chronological order, in line with the time span of a primary health care programme, as follows:

1. success in motivating community and health staff to accept and understand the programme
2. improvement in quantitative and qualitative performance of health facilities
3. change in attitude of health staff
4. success in overcoming constraints and fears
5. change in attitude of the community
6. improvement in basic statistics (Ajmal 1989: 31)

These stages provide a framework for assessing impact on health by ARC/PHC/FPHC over some of the years of the study. Some relationship between Ajmal's stages and the NGO's four developmental phases is identifiable because the Report covers some contemporaneous ARC/PHC activity. Stages and phases do not match exactly, and this thesis deals with a longer period than that covered by the Report. However, Ajmal's model appeals because it emphasises that impact has a qualitative aspect as well as quantitative; he does include a few quantitative references. The qualitative emphasis is of special interest when a fresh concept is being introduced to a distinctive culture from outside. Ajmal's model moreover was developed in the Afghan refugee population, some of whose members are part of this case study, and the author, being indigenous, appreciates the cultural restrictions. I therefore propose to use Ajmal's framework as set out above to discuss qualitative aspects of impact at ARC/PHC/FPHC.

ARC/PHC/FPHC and Ajmal's stages of impact: qualitative data

Impact stage 1: motivating staff and community to accept the CHW programme and the basic initial programme

ARC/PHC 1980-1984

The 1982 Annual Report records the need to build trust with the camp population to create pre-conditions for preventive measures. There is no information on how this was done, but it is reasonable to infer that Dr. Zamani's motivation, authority and ubiquity influenced community attitudes and eventual acceptance and understanding. As an Afghan *khan* he would automatically command respect and obedience. At a time of great need in a chaotic situation, amidst widespread feelings of loss and insecurity, rural Afghan people seem to have been pre-disposed to accept his leadership, much more so than if a non-Afghan tried to impose new ideas. Chapter 3 noted the recommendations of external consultants, mostly from Austria, reinforcing early pro-active and outreach attitudes and practices, such as "self-help" and the use of "scouts" both male and female to seek out people in need of treatment. The consultants also supported the move towards PHC. Their visits were timely, coinciding with Dr. Zamani's pursuit of a different approach from curative "pill-medicine".

Ajmal notes how easy it was for the SCF Team to recruit trainees and have them accepted by BHU staff at Badaber camp where training was first introduced (1989: 31). He attributes this to the motivational climate at the health facilities: staff at service-delivery level (as distinct from senior, distant and often expatriate managers of the Refugee Health Programme) realised that transition to fixed units required extra practical help to render the service more effective. It was feasible for SCF to build on interest expressed by Afghan men in health care for their families, even though the Afghans at first saw it as a matter of treatment rather than prevention (Ajmal 1989: 7). This accords with requests from community elders to ARC representatives in 1980 to provide a medical service (ARC Annual Report 1980). The 1984 ARC Annual Report (p 12) records training of the first cohort of CHWs at ARC/PHC, who lived and worked in the two camps served by ARC at that time (Baghicha and Gandaf).

Dr. Zamani used courses available via SCF to start his own recruitment and training of CHWs (and later female volunteers) at ARC/PHC. Volunteer training continued at the health project throughout the years to 2000 and beyond. More widely, because the Refugee Health Programme sponsored SCF's initial promotion, the policy of training volunteers had a lasting impact on how the Programme operationalised its version of PHC. This understanding of harnessing community energy appears not to have penetrated GOP's system.²

² NWFP Bureau of Statistics records that 1066 TBAs were trained in 1993-4 for GOP, but thereafter "training facilities for TBAs stopped by UNICEF". The UNICEF/GOP scheme had started in 1982.

Impact stage 2: improvement in quantitative and qualitative performance of health facilities

ARC/PHC 1985-1989

Ajmal reports improvement "*in a very short time*" (no exact dates given) in delivery of health services to SCF's target population, once CHWs (and CH Supervisors) had become active (1989: 32-33). He attributes this to regular monthly basic information-gathering about the smaller and more identifiable groups of houses/families for which each CHW became responsible e.g. marriage and birth data. This may appear related to quantitative rather than qualitative data, but the point he is making is that effective implementation of e.g. immunisation and recording of growth monitoring could have occurred *only* through the co-operation of CHWs: as knowledgeable residents in camp communities they formed the essential link with the BHU Team. Planning and implementing different programmes became much easier, Ajmal says.³

ARC/PHC's 1984 Annual Report (p12) makes similar comments to Ajmal's about its first batch of 34 trained CHWs from the camps. They worked with other camp residents to identify malnourished and unvaccinated children, case-finding and follow-up especially of TB patients, as well as giving health education. Strong leadership in the first phase seems to have already created a climate enabling acceptance of PHC. The relevant ARC Annual Report (see chapter 3) states that improvements in health were perceptible as early as 1982, i.e. even before the SCF/CHW scheme started. Training of volunteers at ARC/PHC appears therefore to have been an addition to a service already functional, if limited, claiming to be at least partially effective. CIWs and trained TBAs impacted on work-style in the 1985-89 consolidation phase of ARC/PHC, when recording systems became more informative—even more so when in 1990 ARC published the first separate Annual Report on the PHC Project (see Figure 9.1 for samples of changes in quantitative recording in ten years). Dr. Zamani's insistence on accuracy was not unrealistic, because ARC/PHC staff and CHWs all had to be literate. He built in a reporting system, and himself supervised rigorously. TBAs were not literate, but they reported to LHV's who were all literate and professionally trained.⁴

³ As an example, he quotes the figure of 98% BCG scar coverage in the area, based on a UNHCR random survey (Ajmal 1989: 32)

⁴ Depute EDO (Health) Mardan District complained of the low educational level of GOP BHU staff, affecting reliability of data. But uncertain supplies (even of stationery) and/or other inadequacies of management would contribute to defective returns.

Figure 9.1 Sample of ARC health records for 1980

25

ENDIX 8.6.

A MONTHLY REPORT OF ACTIVITIES
FROM: HEALTH UNIT NO. 3
SERVICE AREA District Mardan

Nov. 1980

DATE	GASTRO ENTERITIS		CHEST INFECT.		T.B.		CONJUNCTIVITIS		IMPETIGO		MALARIA		MEASLES		WHOPPING COUGH		MUMPS		GRIPPE		URINARY TRACT INFECTION		GYNECO-OBSTETRIC		CARDIO VASCULAR DISEASE		WORMS		E.N.T.		COMMON COLD				E.T.C.		TOTAL
	CHILD	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD	ADULT			
11.80	2	2	2	1																															1	11	
11.20			6	2				2	1																									5	21		
01.11.80			4	1																															1	9	
1.11.80			5	3																														12	31		
2.11.80	1	5	6	2																														15	20		
3.11.80	1	1	5	3				1																										10	28		
5.11.80	1	1	1	2																														7	19		
6.11.80	2	1	1	2				1																										16	29		
7.11.80	3	1	1	2																														17	31		
01.11.80	1	1	3	1																															1	8	
2.11.80	1	1	2	3																														28	49		
3.11.80		1	2	3																														27	53		
4.11.80	2	1	1	2																														21	52		
5.11.80	1	1	2	1																														16	49		
6.11.80	1	1	1	1																														16	43		
7.11.80	1	1	2	1																														6	38		
8.11.80	2	1	3	1																														21	71		
01.11.80	1	1	3	1																														24	58		
TOTAL	1620	58	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	24	620				

Source: FPHC Office 2001

Figure 9.1 (contd). Sample of ARC/PHC health records for 1990

<u>Deliveries:</u>	<u>Bachicha</u>	<u>Gandaf</u>	<u>Kacan</u>	<u>Total</u>
Deliveries	475	543	130	1,148
By Lady Doctors	17	13	9	39
By LRVs	2	9	0	11
By Dais	74	133	49	256
By TBAs	338	355	52	745
By Others/family members	44	33	20	97
Percent of supervised del.	90%	94%	84%	89%

Table x. details of deliveries in three camos.

Due to the increasing number of supervised deliveries in our camos, perinatal and postnatal complications have been significantly reduced.

C. POSTNATAL CARE:

Postnatal visits ensure full postnatal examination and immediate evaluation to assess needs, provide special care and identify obvious disorders, such as congenital abnormalities.

These checks also allow for review of TBA and DAI practices, and additional training can be provided.

<u>Postnatal care</u>	<u>Bachicha</u>	<u>Gandaf</u>	<u>Kacan</u>	<u>Total</u>
No. of postnatal visits	473	540	128	1,141
Postnatal coverage	99.5%	99.4%	98.4%	99.1%
No. with antenatal cards	386	519	97	1,002
Antenatal coverage	81.6%	96.1%	75.7%	84.4%
Abnormal deliveries	0	2	4	6
Retention of placenta	0	1	0	1
Perineal tears	0	2	0	2
Postnatal bleeding	0	0	0	0
Postnatal infections	0	0	0	0
Premature babies	18	4	0	22
Babies weight < 3 kg	85	29	36	150

Table x1. Postnatal visits in three BHUs.

Source: ARC/PHC Annual Report 1990: 28 (first separate Report)

Impact stage 3: changes in attitude of health staff

ARC/PHC 1990-1994

Ajmal interprets changes in attitude as staff becoming convinced of the usefulness of CHWs in helping them to do their jobs, so that they began to ask for additional CHWs. By the third phase of ARC/PHC's development 1990-1994, both male and female voluntary workers were well incorporated into its service. Believing that trained volunteers could impact on the reconstruction of Afghanistan when the refugees returned to their homeland, ARC/PHC trained more people than were needed for the work in the camps: in 1990, 57 TBAs and 90 CHWs were trained. (ARC/PHC Annual Report 1990: 36).

But at ARC/PHC change in staff attitudes was not only a matter of accepting volunteer workers. Turnover of doctors (indicators listed in chapter 3) continued as educated Afghans left for western countries (including in 1991 Dr. Zamani himself), or for other jobs, but perhaps less rapidly than in the early years.⁵ New doctors, male and female, who joined ARC/PHC and later FPHC, whether Afghan or Pakistani, were invariably conventionally trained. The public health focus of PHC required some adjustment on the part of these recruits. Some doctors and other trained professionals become converts and committed members of staff. Group interviews in 2001 with four male Team Leaders (all doctors) and with female senior staff (three doctors, three LHVs with some training responsibility) produced evidence of the different mind-set needed for practising PHC, as follows.

An Afghan male doctor, a Team Leader, with previous experience as a surgeon in Afghanistan said *"When I joined the health project in 1990, I thought I knew everything; now I have learned a lot and I know that there is much more to learn"*. A lady doctor (Chitrali), whose previous experience was in house jobs, said *"It is totally different at FPHC from working in a hospital; I think preventive medicine is more interesting. It is an investment for the future—it will help people not to go to doctors"*. Another lady doctor, a Pakistani, talking about working in a private maternity hospital, said *"The ante-natal care was a blood test only, then delivery. The patients were educated rich people, they can go anywhere. There was no interest in poor people or preventive work. Here at FPHC there is curative work but the stress is on preventive, and working with the poor people. I get satisfaction from that"*. *"Since Gandaf HC 2 (village) started, the people have learned about TT vaccinations, measles and polio. I have learned that preventive medicine is better*

⁵ One Afghan lady doctor left for a better-paid job with another health NGO in NWFP, gained apparently on the strength of her several years' service with FPHC (May 1994-October 1999).

than curative. Here I have to attend at 8am every day", said another Team Leader, an Afghan male doctor,⁶ An LHV with 30 years of experience of teaching and multi-purpose work with other NGOs said *"I feel happy now, when I see FPHC honestly working: it is preventive medicine, it is my subject: GOP does it only on paper"*. Another LHV, contrasting working at FPHC with experience at a GOP eye hospital,⁷ said *"At FPHC, no-one is doing for himself, it is doing things for the people. The buildings are looked after. There is a team, it is sincere, it is everyone from top to bottom, everyone works"*. Dr. Wagma, who joined ARC/PHC in 1988, said *"There is freedom to work here, an open feeling. There is not only a doctor/patient relationship but a relationship with the community, and a social relationship with the community as well"*.

Chapter 6 quoted Dr. Emel's and Dr. Wagma's remarks on their changed practice since their conversion to PHC, and the latter's suggestion that a short induction course would benefit conventionally trained practitioners joining FPHC.

Some of the comments above support interview evidence from GOP staff at BHUs and at senior levels, and also opinions recorded by earlier researchers, quoted in chapter 4, on the discrepancy between GOP plans and practice. The Refugee Health Programme's policy of recruiting young Pakistani doctors, following a specific programmes-based period of training, seems to have been insufficient to convert them to appreciation of a health care strategy appropriate for under-served communities. Other comments above indicate that private health care is not necessarily better health care, and that PHC acknowledges—can even promote—positive human relationships between care providers and the patient community, at least in this NGO.

The obstacles, shortcomings and frustrations of the system in which GOP health staff work explain the scarcity of material from fieldwork to indicate attitudinal change by staff which would enable implementation of PHC, even where some individuals had learned something from courses on the topic. There was some evidence of recent official attempts at modifying the curative-oriented training of GOP personnel: the Provincial Health Services Academy (part of GOP's Health Department) and the Khyber Medical College in Peshawar began sending parties of students to visit FPHC Health Centres (FPHC Annual Report 1998: 7).

According to the FPHC Administrator who acted as guide on some of these occasions, the experience appeared to have little impact on the students. Few displayed real interest in the

⁶ Speaking about his previous experience in a GOP hospital, he said that staff from the Hospital Superintendent downwards including himself, came and went as they pleased--*"there was no system"*-- a reflection on waste of time and lack of accountability in GOP's second level of care

⁷ She said there were fights and rivalries among staff at the eye hospital.

activities, and most were inclined to chat among themselves. These young people were likely to follow the standard pattern after house jobs of short-term employment in the Refugee Health Programme, or direct entry to GOP service, perhaps later becoming private practitioners and/or specialists.

Impact stage 4: overcoming constraints and fears

ARC/PHC/FPHC 1995-2000

Ajmal's Report refers to constraints and fears on the part of the community. The model of matching phases of impact with developmental phases of the NGO has its limitations, for constraints and fears among the refugees in the three camps had to be addressed from the earliest years (i.e. before CHWs were introduced). The early ARC Annual Reports provide little detail about the admitted difficulties of implementation and subsequent impact of the health project, but there is anecdotal evidence of refugees' lack of understanding of queuing when they attended a BHU, and the risk of violence, a feature of Afghan culture—even risk to staff. The refugees had to learn patience, and staff had to be resourceful, brave and persistent in difficult circumstances.⁸

“The (Evaluation) Team found that health programmes have taken 5-6 years to capture the target refugee population as a whole. The main difficulty has been to reach the women: a satisfactory attendance of 80-85% was not achieved until 1989” (Rizvi 1993/4: 33).

While Rizvi's Evaluation Report does not explain how this percentage figure was obtained, the statement illustrates the very gradual erosion of cultural constraints. Chapter 8 indicated that there was still in 2001 within the three camps some residual reluctance to allow women to attend, also admitted by patients at the Refugee Health Programme BHU I visited. This was in spite of both agencies including female staff in their teams (Lady Doctors and LHVs).⁹ Kazi attributes women's low attendance at GOP BHUs (especially in remote areas) at least as much to lack of female staff as to the reluctance to allow potential patients to travel outside the home (1999: 381). As in the original SCF initiative, however, the fact that CHWs and TBAs were residents of the camps where they worked probably helped the ARC/PHC refugees to approach and accept them, being familiar people who lived in their midst. Similarly, expansion into the villages necessitated recruitment of villagers as volunteer health workers. The health project's policy of home visiting by LHVs (first

⁸ On joining ARC/PHC in 1988, Dr. Emel Khan (who is Pakistani, not Afghan) kept a revolver on his desk during out-patient sessions. In 1992, a visiting mental health consultant could remark on how popular he was with patients (MMP Journal).

⁹ At this large camp (Shamsatoo), recently re-opened to cope with the “drought” influx of 1999-2000, it is possible that regular patterns of behaviour had not yet been established.

mentioned in ARC's Annual Report 1984: 13) for follow-up and seeking defaulters, especially women, went some way to counteracting cultural restraints. Transport with driver was available to LHVs doing this kind of outreach. Being Pakistani, they were slightly less restricted in movement than Afghan women.

Impact of some programmes at ARC/PHC/FPHC was reinforced by using different methods to convey similar messages, thus addressing such constraints as refugees' illiteracy. For example, the project promulgated health education using simple visual materials from UNHCR and NGOs such as SCF and TAF, designed specifically for illiterate people; BBC Pushtu Service audio-tapes were relayed to waiting patients; LHVs and TBAs provided health education during home visits in the camps; FPHC staff gave health education to the girls' classes in the three children's play parks, and later to some village schools. One of ARC/PHC/FPHC's characteristics was its ability not only to "follow up" (e.g. defaulters) but to "follow through". From time to time NGOs would unexpectedly find themselves recipients from various official sources such as WFP of dietary supplements like cooking oil, dried skim milk or protein biscuits. Apart from arranging distribution of the last two to families, (or via schools as was Dr. Zamani's policy in his time) health project staff routinely instructed mothers or other female relatives in preparing these unfamiliar biscuits for babies and very young children by crushing and mixing the biscuits with milk or boiled water; I saw this being done at the demonstration kitchens. A visiting western health professional remarked that she had not seen this at BHUs of other organisations she had visited. Standard practice was simply to hand out bags of biscuits with no guidance.

Impact stage 5: change in attitude of the community

ARC/PHC/FPHC 1995-2000

The chapter on participation related how some refugee patients had been able to make complaints to senior management of FPHC in a rational and peaceable way—showing how patient behaviour had modified, and how understanding of FPHC's policies had developed over 14-15 years of health education and health care. A senior doctor working at Health Net International (an NGO specialising in malaria), a former employee of ARC/PHC/FPHC interviewed in 2001, told me of staff from another international NGO conducting research on refugee health who had told him of their astonishment at

"the knowledge of preventable diseases displayed by an illiterate Afghan woman at FPHC, much more so than at other agencies" .

The fact that children's parks and classes for girls have been established at all three of the original Health Centres is another indication of impact on community attitudes. Gandaf park and class was set up in 1989; there was no enthusiasm at the other camps—indeed some resistance—in spite of an offer from management. Then in 1994 Baghicha camp elders approached FPHC and asked for a park and class; the Kagan facility followed at the community's request, as soon as finances allowed.

Impact stage 6: improvement in basic statistics

Having decided to deal separately with quantitative data, I shall not discuss Ajmal's sixth stage of impact at this point in the chapter. However it is appropriate to share some qualitative data concerning the impact of FPHC's service on local villagers—the additional target population acquired from 1995 onwards.

FPHC and qualitative data: Ajmal's framework and the fourth phase of the health project's development 1995-2000

and Austria approved and supported the expansion into villages, having accepted the 1993/4 Evaluation's recommendation of the health project's impact on non-refugee local people as a foundation for development (Rizvi 1993/4: 34-35). In some ways it was not straightforward expansion, but back to the beginning. Senior FPHC staff were probably justified in believing that the starting point of outreach to villagers in 1995 would be more advanced than it had been with the refugee group in 1980. Those had been people in crisis, coming from remote areas of a country perceived as less developed than Pakistan. Ajmal's indicators are therefore less applicable to the work with the village population, but those regarding **motivation, improvement in performance of health facilities, constraints and fears** are useful.

Firstly, some misconceptions about FPHC may have affected villagers' motivation. Before the new 1995 policy allowing them to access all programmes, villagers had been accepted at ARC/PHC for basic curative treatment only, so long as it did not prejudice the comprehensive service to the refugees. Now villagers had to learn that what they had opted for was different: prevention of ill-health was a new idea to many. By 1995, FPHC staff were well-motivated, confident and experienced in PHC.

Secondly, there is evidence of quite rapid improvement in quantitative and qualitative performance of health facilities. The first Annual Report (1995) of the newly constituted NGO FPHC notes overall increase in many activities compared with 1994, ranging from an

increase of 12% in the number of children fully immunised, to 150% of women attending for family planning, and 258% of women immunised against tetanus (p 20). The Report ascribes the increases to the influence of additional volunteer workers, male and female, recruited from villages and trained by FPHC, and also to the effect of offering services to people to whom they were not previously available. However, this first FPHC Annual Report explains that the percentages quoted make no distinction between the original refugee target population and the villagers:

"In previous years almost 100% of the static camp population (i.e. in the three ARC/PHC camps) used ARC/PHC services. We could say for example that nearly 100% of pregnant women attended for antenatal care, and of that number, almost 100% had supervised deliveries. In 1995, because of the increasing target population, more women attended for antenatal care and more had supervised deliveries; but we do not know how many other pregnancies and deliveries did not receive FPHC care. In other words, programmes are available, but uptake, though increasing, is gradual. This is likely to be so for as long as FPHC is in a phase of expansion" (FPHC Annual Report 1995: 7)

This extract from the 1995 FPHC Annual Report was written at the time by JSP¹⁰. His remarks are based on the final Annual Report of ARC/PHC (1994:12) which records 1184 deliveries in the camps, 4 of these unsupervised; 96.8% of these mothers had attended for ante-natal care. The quotation agrees with Ajmal's statement that a PHC programme takes time to be effective; impact will probably be gradual even when the target population is relatively receptive to it, as the villagers were.

In 1996, a small expatriate team from Mothercare (John Snow International) undertook a *"Rapid Health Facility and Capacity Building Assessment"* of five NGOs, including FPHC, which it subsequently recommended for an award from the USAID-funded "Pakistan NGO Initiative Project" of The Asia Foundation (TAF). This team confined itself to the MCH programme at Kagan Health Centre only. Its generally positive Report (qualitative rather than quantitative) remarks on

"virtually 100% immunisation of mothers and children, laboratory use, warm and responsive relationships between health care workers and clients"

It is not clear whether this visiting team appreciated that Kagan Health Centre served both refugees and non-refugees. The 100% coverage they quote may be subject to the reservation quoted above from the 1995 Annual Report, but this does not invalidate their observation on the staff/patient relationship. The 1996 Annual Report in discussing impact across the (by

¹⁰ The 1994 and 1995 Annual Reports were jointly written by MMP and JSP, using statistics compiled by FPHC Office staff, on the basis of monthly returns from the Health Centres.

that time) total 58,000 target population served by four Health Centres (i.e. 28,000 villagers in addition to 30,000 camp residents) echoes the caution of the 1995 Annual Report regarding impact on the village population:

"In the next year or two FPHC must strive to bring the services and the health indices in the local villages up to the high standard enjoyed by the refugees" (FPHC Annual Report 1996: 25)

—and four years later, the Annual Report 2000 notes that encouraging support groups in the community which FPHC had started

"is still a tiresome job in some parts of FPHC's target area. In the meetings of support groups, information on different health issues is shared, whereas the members (i.e. non-refugees) expect purely curative services" (2000: 5)

These comments further emphasise Ajmal's observation that community attitudes need time to change, just as was the case with the refugees in early ARC/PHC years. The 1998 External Evaluation makes little use of quantitative data in its positive report on FPHC, compared with the 1993/94 Evaluation, but it notes development in style and scope of its activities (Rizvi 1998: 5). During my fieldwork, comments from FPHC staff demonstrated that they understood the need for perseverance on their part. Female staff at the Wardaga Health Centre (MCH only) remarked that

"once they understand the need for care, they never neglect the (antenatal care) service" (interview 2001—the inference being that it took some time).

One of FPHC's Master Trainers in its Human Resources Unit, a camp resident who has worked in the health project since the mid-1980s, considered that it took about seven years for health education to be really effective. Dr. Shabina's 2000 Evaluation which is more detailed in its study of health care delivery than the 1998 exercise, and includes patient exit interviews, implies in its conclusion that penetration of the village population by the FPHC service remained a slow process:

*"FPHC has managed to maintain the present health conditions of the PHC target groups (i.e. the refugees) and **has improved the health of local people to quite an extent in nearly all areas towards the levels achieved for the refugees**"* (Raza 2000: 5, emphasis mine).

Thirdly, constraints and fears persisted among the villagers. Their level of knowledge was limited. Staff found that some village mothers were so unfamiliar with the mild feverish reaction to an injection that they were afraid to let their children be vaccinated, whereas refugee mothers had learned long ago that this was not unusual in babies. At Wardaga HC (started 1997), where villagers had specifically asked for a MCH-focussed service, staff said

there was a large educational task, because the perception in the community was that pregnancy is a normal condition requiring no special care, so that antenatal care had to be promoted vigorously¹¹. The tendency of Wardaga villagers to prefer attractively packaged proprietary medicines bought from private dispensaries to basic drugs available from FPHC at its new medicine bank also illustrates entrenched attitudes inhibiting change.

SECTION B: QUANTITATIVE DATA

Justification for limitation to MCH data

For this thesis it was not realistic to analyse all categories of quantitative data relevant to primary health care as practised at ARC/PHC/FPHC—nor I believe even necessary—in order to assess impact on the health status of FPHC's target populations. The figures incidental to the text above are there to support the qualitative material. For a more detailed assessment of quantitative data as indicators of impact I have chosen to restrict them to the category of mother and child health, because

- a) *The Declaration of Alma Ata supports this choice.* Several of its Articles and Recommendations mention the special significance of the preventive and health promotive thrust of PHC for mothers and children. The Declaration also emphasises care for the poor and for remote and/or rural communities.¹²
- b) *Indicators of human development:* Throughout the period covered by this thesis, World Development Reports (WDR) and Human Development Reports (HDR) have consistently cited infant and child mortality (and sometimes low birth weight and contraceptive prevalence) as prime indicators of general health standards and of living standards more generally. See, for example, WDR 1982: 144 and 150; WDR 2000/2001: 276, 286; HDR 1990: 134, 146 and 166; HDR 1998: 145, 150 and 156. The Alma Ata Declaration includes family planning in MCH and appropriately so, but I propose to discuss family planning later in the chapter and on its own, partly because of the long

¹¹ One approach was to use the analogy of the buffalo which is given extra food to ensure a big healthy calf.

¹² Article VII(3): In listing the components of PHC, says "Primary Health Care ...includes at least ...maternal and child health care, including family planning; immunisation against the major infectious diseases". This is reiterated in Recommendation 5. Recommendation 1 which says "Recognising that health is dependent on social and economic development and also contributes to it, recommends that governments...strengthen primary health care within their national development plans with special emphasis on rural and urban development programmes..."

Recommendation 8 recommends that "high priority be given to the special needs of women, children...and the underprivileged segments of society"

Recommendations 10, 11 and 19 mention supports such as staff training and incentives for meeting the needs of underserved areas and groups.

history of family planning in Pakistan, and partly because for Pathans and especially refugee Pathans it appears to have a special significance.

- c) *MCH data give a broad picture of health status:* In assessing impact of a primary-health-care-oriented NGO, data on 75% of a population targeted by more than one primary health care programme (e.g. EPI as well as family planning, all relevant to MCH) are likely to provide a broader picture of health status, than data on e.g. one disease such as malaria. Data on a single disease which can affect both sexes and all ages would have been much easier to collect and simpler to present, but it would have addressed only one sub-category of one component of primary health care, i.e. control of endemic diseases, and it would have given less insight into the health status of the community.
- d) *MCH data cover a substantial proportion of the population, both refugee and non-refugee,* in the area with which the case study is concerned—75% according to the figures below. Living conditions in camps and villages are similar: both groups belong to the category of rural poor, for whom the Declaration is particularly concerned (see footnote was no.12)

ARC/PHC/FPHC target population data—refugees and non-refugees

Refugees: In 1992, the result of a house-to-house check of numbers in the three camps as follows:

Children 0-14 years	55.7%	
Women	22.2%	
Men	22.1%	(ARC/PHC Annual Report 1992: 6)

This Annual Report also notes that outflow from the three camps back to Afghanistan in 1992 was much less than from other NWFP camps, indicative of their settled state. It also clarified that the estimate of 30,000 refugees in the camps was too high—the survey calculated a total of 23,440 persons.¹³ The UNHCR Mission in Pakistan in reporting to Headquarters in Geneva on Afghan refugee statistics for 1991 admitted it was unable to provide a breakdown by age and sex of the refugee caseload. ARC/PHC appears better informed about its (admittedly small) share of the 3.5 m. refugee population around the same time:

"With regard to the Afghan population, we have spent an inordinate amount of time trying to obtain an accurate demographic breakdown. However the sheer

¹³ The approximate populations for the three camps at this time were Gandaf 10,000, Baghicha 8,5000 Kagan 5000. By year 2000, Gandaf camp had increased to about 15,000 people.

magnitude of the population coupled with their dispersion throughout the country adds to the complications explained in our 23 June telex: neither births nor deaths of the Afghan population have ever been recorded. Widespread migration of able-bodied males into numerous directions results in split families. Furthermore, there is no way of knowing the numbers of unregistered and non-assisted Afghans in Pakistan. Consequently, estimating the demographic profile of Afghans in Pakistan simply cannot be done in a meaningful way. What we can state however is that in comparison with the Afghan population in Iran, the population in Pakistan has a far higher percentage of women and children"
(UNHCR Islamabad 1994: fax ref PM/234 to HQ Geneva). ¹⁴

Villagers: ARC/PHC/FPHC’s 1994 and 1995 population surveys of villages in the neighbourhood of the three camps produced the following information:

Table 9.1 ARC/PHC survey of villages Zando, Rashaka, Kagan 1994

<i>Age Groups</i>	<i>Age Range</i>	<i>%age</i>	<i>Total</i>
Children	0-4 years	19.1%	49.1%
Children	5-14	30%	
Women	15-45	21.3%	25.7%
Women	46+	4.4%	
Men	15-45	21.3%	25.2%
Men	46+	3.9%	

Source: ARC/PHC Annual Report 1994: 8

A survey of three other villages in 1995 produced similar figures:

Children	49 %	(FPHC Annual Report 1995: 6)
Women	24.8%	
Men	26.2%	

While preparing for ARC/PHC's transition into FPHC, a d c Austria and health project management regarded these figures as evidence that the three camps had become settled communities, because the percentages corresponded roughly with what was known about population structure in the three camps. The surveys did not collect data on birth rates nor on family size.

Disadvantages of choosing MCH data

One disadvantage of considering only MCH data is that it ignores men's health. Alma Ata's slogan of “*Health for All* ” clearly includes them, as does Recommendation 8’s mention of the need to pay attention to health care for “*working populations at high risk*” (which may

¹⁴ UNHCR Archives in Geneva were unable to produce any records for 1995 onwards relating to Afghans in Pakistan (search/visit in November 2002).

also apply to women). While it applauds prioritising MCH, WHO warns against the exclusion of fathers as not necessarily serving the best interests of the family, the critical social unit of the community (WHO 1988: 48). Another disadvantage of focussing on MCH data is that it excludes matters of women's or children's health unrelated to their gender or age group e.g. a broken leg or an episode of respiratory tract infection can affect an individual of either sex and of any age. Family planning does not exclude men, but is more often than not perceived as women's responsibility, and not only in Pakistan. Nevertheless, allowing for these possible disadvantages, examining MCH and Family Planning should help to place ARC/PHC/FPHC in the context of the other services for the populations concerned.

Some cautions—about routine data generally

All quantitative data, especially if collected routinely, is subject to recognised possible shortcomings, including inaccuracy, bias, failure to complete, irregularity, falsification. Data may be destroyed or lost, risks which increase with the passage of time.¹⁵ The distinctive features of Pathan culture may inhibit communication on intimate subjects, especially with a foreign interviewer.¹⁶ The World Development Report warns that in developing countries, data are available only at periodic intervals, registration systems exist in only a few, and surveys are conducted at different times. They are also conducted by different agencies using different methods, all of which combine to produce inconsistent results (WDR 2000/2001:18).

—and about data in Pakistan: specific problems

Unreliability

Basic quantitative data relating to health in Pakistan are particularly unreliable. Many writers have made this criticism, noted in chapter 4. The Depute EDO (Health) of Mardan District warned that if I obtained any data from Provincial Health Department I should not regard it as accurate—*"it will give you a clue, only a clue"*. As mentioned above, he criticised the low educational level of GOP BHU staff, affecting their ability to return correct information. Two other doctors working for the Provincial Health Department referred quite openly to *"rubbish figures"*. Gazdar, discussing the problems of analysing poverty trends in Pakistan

¹⁵The destruction of early ARC Annual Reports by insects mentioned in chapter 3 is an example.

¹⁶ UNHCR observed in 1981 that enumeration difficulties were not peculiar to Afghan refugees (especially women) but were encountered by GOP in counting the local population, particularly in tribal areas. (UNHCR 81: 1 Cable Islamabad to Geneva). Another UNHCR communication (Barnes: 1986: 1) remarks that *"censuses in Pakistan are minimally adaptable to modern techniques of accounting, and that the mere conduct of a census is essentially a contest of wills between refugee leaders and government authorities"*.

refers to “*the non-availability of consistent time series*”, (Gazdar 1999: 243) a comment which explains some gaps in tables later in this chapter.

Inadequate recording systems

Recording instruments supplied to GOP BHUs do not facilitate collecting precise information. Records are maintained in large heavy bound volumes—“Registers”—for noting individual diagnoses¹⁷ or prescriptions of e.g. contraceptive methods/devices. GOP BHUs do not use “Family Cards” so that there is no readily available picture of the health status of a family group; if cards were retained by the family it might encourage them to develop responsibility for their own health, and might also help to personalise the service. The effects of staff absenteeism, inadequate supervision and lack of integration with TBAs, the people likely to have most information about births and newborns, all as mentioned in previous chapters, contribute to the uncertainty of Pakistan’s health statistics. Neither GOP nor the Refugee Health Programme BHUs included a clerical member of staff. One duty of the long-established Registrar post at ARC/PHC/FPHC Health Centres was to ensure regular monthly submission of report forms from team staff.¹⁸

Management and analysis of data

Not only data from GOP basic units are less than satisfactory. The Pakistan Health and Welfare Atlas published by Planning and Development Division of GOP in 2000 contains data incorrectly categorised or inconsistent e.g. tabulated figures do not agree with information on corresponding maps; entries in columns for number of households and relevant population figures have been transposed. Such errors suggest either inefficiency or inadequate understanding, or both.

Afghan refugee data, including health

Statistics for refugee populations, wherever in the world they are located, are problematical:

“Census data are never wholly reliable, and this is especially the case with those collected under the conditions which obtain in this part of the world”
(Harrell-Bond 1986: 389).

She was writing about Africa, but the statement is just as applicable to the Afghan/Pakistan case. There is an inherent difficulty in counting refugees. It is advantageous to exaggerate family size when there is an expectation of material benefits, and conversely a good idea to minimise it if any financial or other burden is anticipated. In practice, aid workers (including

¹⁷ At a visit to a Charsadda District BHU in 2001, recorded diagnoses were vague, e.g. “fever” or “RTI”.

¹⁸ FPHC Registrars have a petty cash float for small local purchases, and have to submit monthly accounts to FPHC Office in Mardan. GOP BHUs have no cash at their disposal.

those in health) as well as heads of families may exaggerate numbers and/or fail to report deaths, in order to obtain maximum supplies of food or medicines¹⁹. In NWFP, cultural factors inhibited obtaining information about refugee numbers so that under-reporting was common. Regarding refugee health statistics, Ajmal (whose observation is based on a close relationship with refugee health work at the time) makes the categorical statement that reliable health data for the area in which SCF was trying to introduce the CHW scheme were not available for the period before the PHC intervention of 1983 (1989: 31). He extends this opinion to the whole of the Afghan Refugee Health Programme at that time.

The work of the Programme Officer (Health), a lady doctor at UNHCR in Islamabad, who had worked in the Refugee Health Programme since 1982, remained affected at time of interview in 2001 by problems of enumeration, which consequently influenced accuracy of health data. She questioned the official estimate of 1.2 million refugees in the camps, averring that 1.4 million was nearer the mark for practical purposes—

"—and another 500,000 in among the general population, which makes them even more difficult to count"

Recording as well as service delivery had become still more difficult in 1999 when the "drought" influx of refugees began arriving in NWFP. She considered what was then the official refugee population estimated increase of 3.1% p.a. to be affected by under-reporting *"we are taking 4%"* she said. She appeared at least as overloaded as the EDOs (Health) of GOP. She was also responsible for a larger more dispersed population, including the recent arrivals accommodated in the re-opened camps of Jallolai and Shamsatoo, many presenting as malnourished. In earlier years there were three staff at her grade, but financial cutbacks in 1995 left her in 2001 as the only person with strategic responsibility for refugee health.

All this means that efforts by the Refugee Health Programme to maintain accurate quantitative data on the health of refugees in NWFP have functioned in a climate of chronic uncertainty and recurring pressures. Both the Programme Officer in Islamabad and senior staff at the UNHCR (non-health) Office in Peshawar expressed doubts in 2001 as to availability or even existence of statistical data for many years of the Refugee Health Programme—the latter declared *"we do not retain them"*.

The Refugee Health Programme does require NGOs serving refugees (and presumably its own teams as well) to submit monthly returns to Project Director Health (PDH) in Peshawar. In 2002, both PDH and the lady doctor on his staff responsible for primary health care said they were unable to supply any back-dated reports or health data, both of them on the

¹⁹ This may be a factor in the variable population figures of the three camps, particularly in the early years.

grounds that they had been in post less than a year. Further attempts to discover comprehensive statistical information via UNHCR in Islamabad and UNHCR and WHO in Geneva have been unproductive. In the late 1990s, the Refugee Health Programme called in a team from the Center for Disease Control, Atlanta (CDC) to devise an improved Health Information System (HIS). This suggests that recording and analysis of refugee health data had been recognised as unreliable for some time. The newly devised instruments created prolonged software problems for Programme implementing partners, including FPHC.²⁰

Quantitative data at ARC/PHC/FPHC: results

Over the twenty years 1980-2000, the increasingly wide range of ARC/PHC/FPHC's programmes generated a great deal of numerical data, much of it concerned with **volume of work rather than impact on the patient population**.²¹ Dr. Zamani's insistence on accuracy does not mean that 100% accuracy was achieved, bearing in mind the fluid early situation, staff turnover and inevitability of human error. But he had created a conscientious attitude and an appreciation that accurate records are important in public health. However, Annual Reports especially in the earlier years do not always provide full or consistent quantitative data, nor do my notes on the missing Annual Reports.

Table 9.2 Infant Mortality Rate (IMR) and Under-5 Mortality Rate, Population served by FPHC, 1984 to 1994

Year	IMR	<5MR	Numbers of Births
1984	160	226	N/a
1985	80	110	642
1986	50	72	N/a
1987	55	32	N/a
1988	32	49	680
1989	31	47	N/a
1990	37	50	1018
1991	20	27	1087
1992	20	28	1086
1993	16	16	1131
1994	24	21	1154

Source: compilation from ARC/PHC Annual Reports, as available.

Notes: 1) Under-5 mortality rate is the deaths of all live-born children less than five years old per 1000 children aged less than five years old at the beginning of the year in question.
 2) Numbers of infant deaths and numbers of under-5 deaths are not specified in sources cited.
 3) Numbers of under-5 children in population are available only for 1992(5309) and 1993 (5306).

²⁰IRIN News reported on 20.4.03 IRC (International Rescue Committee) had joined with CDC to develop "an updated surveillance system for Afghan refugees", quoting a welcome by the Programme Officer. This seems to be a further development from the 1990s work and may indicate the magnitude of the task.

²¹ Much health data produced by GOP's Federal Bureau of Statistics are numbers e.g. of children vaccinated or injections given, rather than rates of coverage: "excessive quantity of data is now being collected with little being analysed particularly at provincial and district levels" (National HMIS Overview: 1 20.04.04)

Rizvi's External Evaluation Report of 1993/94 took particular note of the dramatic decline seen in the table above. The three veteran FPHC staff members interviewed in 2001 attributed this decline to the training of TBAs, which they said reduced the incidence of tetanus. Dr. Zamani's opinion at interview was that other factors were also influential, including health education, both individual and collective, immunisation, and treatment of malnutrition, by issuing dietary supplements and ferrous sulphate tablets, all noted (but without detail) in my notes on the Annual Report of 1982. Immunisation became possible by hiring a trained vaccinator²² in 1982 and getting help from UNICEF with a cold chain and vaccine supplies.

In the late 1990s, Dr. Emal Khan suggested to me that some of the figures included in the 1993/4 Evaluation were less than accurate, especially regarding Baghicha camp. He thought this was due to some under-reporting of infant and under-5 deaths; he considered under-reporting of births less likely. This is perhaps not unconnected with the local cultural tendency to wish to please one's seniors. But even if the returns were only half as good as the records indicated (and in his opinion such a large discrepancy was not likely) they demonstrated a performance by the health project far in advance of GOP nationally, and a much greater impact on the prospects for young children in the three camps than GOP had on the equivalent village population. Tables 9.3 and 9.4 show this as far as is possible over the 20-year period.

Table 9.3 IMR per 1000 live births for FPHC, NWFP and Pakistan 1980-2000

<i>Unit</i>	<i>1980</i>	<i>1985</i>	<i>1990</i>	<i>1995</i>	<i>2000</i>
FPHC	150+	80	40	25	29.7
NWFP	109	93	90	80	79
PAKISTAN	94	116	105	85	85

Sources: FPHC: compiled from Annual Reports, relevant years
 NWFP: for 1980, 1985, 1990 and 1995 Social Policy and Development Centre (SPDC) Karachi (Annual Report 2000: 220; figures relate to nearest available years); for 2000, GOP/UNICEF Multiple Indicators Cluster Survey (MICS: 2002: xiii, figure for 2001))
 PAKISTAN: for 1980, 1985, 1990 and 1995 Annual Report SPDC (2000: 220, figures for nearest available years); for 2000, Human Development Report (HDR 2002: 6)

²² This man is Pakistani, trained in Pakistan, and still working as Immunisation Supervisor with FPHC in 2002.

Table 9.4 < 5 MR per 1000 live births for FPHC, NWFP and Pakistan 1980-2000

<i>Unit</i>	<i>1980</i>	<i>1985</i>	<i>1990</i>	<i>1995</i>	<i>2000</i>
FPHC	Over 200	100	50	30	46
NWFP	N/a	N/a	N/a	116	130
PAKISTAN	180	N/a	136	123	110

Sources: FPHC: compiled from Annual Reports as above

NWFP: for 1995, GOP/UNICEF (MICS 2002: vii, 1998 figure); for 2000, SPDC (Annual Report 2000: 220, 2001 figure).

PAKISTAN: for 1980, World Development Report 1998/9; for 1990, WDR 1991; for 2000, HDR (2000: 3)

Note: All FPHC figures up to and including 1995 refer to refugees only

Other MCH data at ARC/PHC/FPHC

The MCH Programme at ARC/PHC/FPHC had a number of components:

1. Antenatal coverage
2. Deliveries supervised by trained personnel
3. Post-natal coverage
4. Babies <2.5 kg
5. Children immunised

1. Antenatal coverage

ARC/PHC Annual Reports indicate early introduction of MCH care. My notes on the ARC Annual Report of 1982 record an aim of seeing each woman at latest from the seventh month, but if no lady doctor was available—often because of departure to western countries—MCH simply collapsed (see chapter 3). Even if such collapses recurred more than once, they were probably temporary, since all subsequent early Annual Reports record an MCH programme as functioning. By 1991, the aim was to have every pregnant woman attend for monthly check-up from the fourth month onwards, and more often in the last month²³ (ARC/PHC Annual Report 1991: 7). The same report admits that this was not achieved, since average time of recruitment was around the fifth month. But between 1990 and 1991, the percentage of camp women receiving antenatal care had risen from 87.6% to 92.5%. By 1994, the final year of ARC/PHC, this had increased to 96.8% (ARC/PHC Annual Report 1994: 12). The aim was still to recruit by the fourth month; while the Report does not say whether this was achieved, the average number of antenatal visits was 4.7. Home visits to

²³ Check-up included medical check-up, regular examinations (BP, weight, blood, urine) advice re problems, health education re care of newborn, diet, personal hygiene, distribution of supplementary food (ARC/PHC Annual Report 1984: 11)

defaulters and small inducement payments to TBAs (noted in chapter 3) to bring women for examination had been established for some years. In 2000 the average number of antenatal visits was 3.3, and the 2000 Evaluation (covering six months of that year) notes an average of 3.5 antenatal visits to Health Centres (External Evaluation 2000: 18). These later figures may not distinguish between refugee and non-refugee population, which could account for the apparent reduction. Table 9.5 shows some comparative figures.

Table 9.5 Percentage of antenatal cover FPHC, NWFP and Pakistan 1980-2000

<i>Unit</i>	<i>1980</i>	<i>1985</i>	<i>1990</i>	<i>1995</i>	<i>2000</i>
FPHC	N/a	N/a	87.6%	96.8%	95%
NWFP	N/a	N/a	18%	22%	35%
PAKISTAN	N/a	N/a	26.7%	31%	27%

Sources: FPHC: compiled from Annual Reports; for 1995, figure is for 1994
 NWFP: for 1990, Raza (2000:17); for 1995 and 2000 GOP/UNICEF MICS (2002: xiii)
 PAKISTAN: for 1990, Raza as above; for 1995 GOP UNICEF MICS as above; for 2000 WHO (2004)

Notes: FPHC figure for 1995 is for refugees only.
 NWFP figure for 1995 specifies "any provider"; for 2000 specifies "trained provider", number of antenatal visits per woman not stated
 PAKISTAN figure for 1995 specifies "any provider".

2. Deliveries supervised by trained personnel (MO/LHV/TBA)

Several ARC/PHC/FPHC Annual Reports note the Pathan tradition of delivery at home, with attendance by a TBA or a family member, usually mother-in-law.²⁴ Among the refugees there was little knowledge of hygiene; the training for TBAs in 1982—all camp residents—who were supplied with clean delivery kits was an important innovation (my notes on the Annual Report). Table 9.6 overleaf shows the increase in number of supervised deliveries as more TBAs were trained and paid staff also increased in number. The Annual Report of 1985 states:

"30 TBAs have been trained in both camps. The training lasted six weeks, three days per week, and was conducted by our female doctors and LHVs. The training used the SCF(UK)'s methods and curriculum" (ARC Annual Report 1985: 23).

²⁴ GOP's Population Welfare Division quotes 87.7 % deliveries at home in NWFP, against national figure 76.7% (PWD 2004)

Table 9.6 Percentage of deliveries supervised by health staff in FPHC, NWFP and Pakistan 1980-2000

Unit	1980	1985	1990	1995	2000
FPHC	N/a	15-25%	MO/LHV 4.4%	MO+LHV +TBA	MO/LHV 5.2%
			TBA 87.2%	97.6%	TBA 94%
			Total 91.6%	97.6%	99.2%
NWFP	N/a	N/a	11.6%	N/a	28%
PAKISTAN	5%	N/a	24%	19%	20%

Sources: FPHC: compiled from Annual Reports as above

NWFP: for 1990, Raza (2000); for 2000, GOP/UNICEF (2002:xii), figures relate to 2001

PAKISTAN: for 1980 (estimate) World Bank.2004; for 1990 WDR; for 1995

GOP/UNICEF

(2002:xiii, figures relate to 1998/99); for 2000, World Bank (2003)

Notes: FPHC 1985 figure is based on 146 deliveries "assisted", out of 386 "registered cases"; and between 600-1000 likely births; 1995 Annual Report does not separate MO/LHV/TBA figures

GOP/UNICEF MICS (2002: xiii) also reports 75% supervised deliveries including TBAs for NWFP, and 78% supervised for Pakistan in 1998/99

PAKISTAN 2000 figure specifies "skilled health staff"

The low figure for 1985 indicates the slow rate of "capturing" the female population in the two camps served by ARC/PHC at that time. In 1990, 8% deliveries were still attended by untrained personnel—"others/family members" (ARC/PHC Annual Report 1990: 28).

Achieving nearly 100% supervised births in the camps in the later years may appear incompatible with the residual reluctance to let some women attend the Health Centres, still evident in my 2001 patient group interviews. This is not necessarily so, because Pathan men are much less likely to object to a female attendant entering the house to assist at a birth (traditionally a female sphere) than they are to forbid going out to attend a Health Centre. At ARC/PHC/FPHC it was the rule for TBAs to be trained.

3. Post-natal coverage

The ARC Annual Report 1982 mentions efforts by doctors to see new-borns 24 hours after birth, but does not say how far these were effected. ARC/PHC Annual Report 1988: 14 states that staff training included instruction on post-natal care, but does not record how many mothers received it. By 1990 (first separate PHC Annual Report, with more detail including the third camp, Kagan) post-natal coverage had increased dramatically (see Table 9.7).

Table 9.7 Percentage of post-natal coverage (home visit by trained staff) FPHC, NWFP and Pakistan 1980-2000

<i>Unit</i>	<i>1980</i>	<i>1985</i>	<i>1990</i>	<i>1995</i>	<i>2000</i>
FPHC	N/a	N/a	99.1%	? 100%	? 100%
NWFP	N/a	N/a	N/a	N/a	25.1%
PAKISTAN	N/a	N/a	N/a	N/a	27.6%

Sources: FPHC: compiled from Annual Reports as above

NWFP: for 2000: GOP Population Department

PAKISTAN: for 2000: GOP Population Department

Notes: ARC/PHC Annual Report 1985 mentions home visits by LHVs, but gives no quantitative data. ARC/PHC Annual Report 1990 records 99.1% visits to those who had supervised deliveries; 1995 and 2000 FPHC Annual Reports state “almost 100% of those who had antenatal care”— but see below re 2000.

I found that data on this element of maternal care was seldom recorded, except at ARC/PHC/FPHC. According to the 1990 Annual Report, post-natal checks as well as including full post-natal examination allowed review of TBA practice (ARC/PHC Annual Report 1990: 28). In year 2000:

“we understand we are quite accurate in collecting information regarding deliveries in camps (and therefore post-natal data), but in villages we are gradually establishing the system” (FPHC Annual Report 2000: 10)

In other words, the number of pregnancies in villages was not known.

The Evaluation of 2000 found that

“though reporting of births was quite efficient, deaths were hidden by village health workers as it would reflect bad on them. The situation in Afghan camps was different, reporting was quite accurate”. (Raza 2000: 37)

This Evaluation describes FPHC postnatal practice:

“Presently, FHWs report nearly every birth in her locality to the Health Centre, which the LHV then visits at home and motivates for postnatal check-up and immunisation” (Raza 2000:38).

4. Low birth weight babies

The figure of < 2.5 kg birth weight is the indicator sometimes used in global Development Reports, but sometimes it is “low birth weight”, with no figure specified. Early ARC/PHC Annual Reports refer several times to malnutrition among children but do not mention birth weights until 1988:

“High weight of newborns was extremely encouraging: 82% weighed more than 3kg. 39% deliveries were supervised by LHVs and ARC-trained TBAs”. (ARC Annual Report 1988: 14)

Tables 9.5 and 9.6 above (Ante-natal care/Supervised deliveries) show that these figures increased considerably by 1990; the 1990 Report uses <3 kg as the indicator for newborns. It records 150 babies of less than 3kg out of a total 1,148 births = 8% i.e. 92% of babies were 3kg or over, 89% of births being supervised by trained personnel in that year. Table 9.8 below shows some comparative figures.

Table 9.8 Percentage of low birth weight babies FPHC, NWFP and Pakistan 1980-2000

<i>Unit</i>	<i>1980</i>	<i>1985</i>	<i>1990</i>	<i>1995</i>	<i>2000</i>
FPHC	N/a	N/a	8%	1.4%	? 2%
NWFP	N/a	N/a	N/a	N/a	? 40%
PAKISTAN	25	25	25	25	21

Sources: FPHC: compiled from Annual Reports as above; the 1995 figure relates to 1994

NWFP: for 2000: GOP /UNICEF (2002: x)

PAKISTAN: for 1980, 1985, 1990, 1995 figures Raza (2000); for 2000, WHP (2004)

Notes: For FPHC the 1995 figure is for refugees only; for 2000, no exact figure is stated, but the bar chart in the Annual Report includes both refugees and non-refugees. It suggests this approximation for both groups, and is subject to the reservation about village births noted above. This report also indicates a considerable drop in low birth weight in village babies between 1997 and 1998 (from 30% to about 2%) but offers no explanation (FPHC Annual Report 2000: 12).

For NWFP, GOP/UNICEF 2002 states "*40% of mothers reported her baby to be weak or very weak. This was used as a proxy for low birth weight and requires care in interpretation*". For PAKISTAN, the 2000 figure relates to 1995-2000.

5. Children immunised

The first mention of immunisation occurs in my notes on the 1982 ARC Annual Report, but with no details. The 1984 Report mentions vaccination of under-5 children, school children, pregnant women and all women between 15 and 40 years. It does not specify vaccinations, but stresses the role of CHWs in identifying unvaccinated children and ensuring that they are taken to the clinics for registration. The 1985 Report states that an immunisation programme for under-5s included BCG, Polio, DPT, DT and measles (ARC Annual Report 1985: 20). It lists doses 1-3 where appropriate, plus boosters, and records TT vaccinations for women. Numbers of attendances of children and women are substantial—total 6377 (1985: 18) but does not record either numbers or percentage of the target population covered.

The detailed account of immunisation in the very full 1990 first separate Annual Report of the health project claims coverage rates between 91% for measles vaccination to over 100%—up to 113%—for OPV, BCG and DPT. This ARC/PHC Annual Report explains that these

rather unexpected figures are due to vaccination of children not fully immunised the previous year, in addition to the target group. For tabulation I have settled for the lower figure of 91%.

Table 9.9 Percentage of children immunised: FPHC, NWFP and Pakistan 1980-2000

<i>Unit</i>	<i>1980</i>	<i>1985</i>	<i>1990</i>	<i>1995</i>	<i>2000</i>
FPHC	N/a	6377 Attendances	91%	109%	99.3% refugee chn. 86.5% village chn.
NWFP	N/a	N/a	N/a	N/a	57%
PAKISTAN	1-6%	30-62%	50-80%	47-73%	61.5%

Sources: FPHC : compiled from Annual Reports as above

NWFP: for 2000, GOP/UNICEF (2002: xvi)

PAKISTAN: for 1980,1985,1990, 1995, ranges identified from WHO/UNICEF's *Review of National Immunisation Coverage* (see below); for 2000, UNICEF (2003: 2-6)

Notes: FPHC: the >100% figure for 1995 is said to be due to a number of new families moving in "especially to Kagan camp" (FPHC Annual Report 1995: 9); for 2000 the figures are for refugee and non-refugee <1 year fully immunised (BCG, DPT3, Poliomyelitis 3, and Measles).

NWFP 2000: GOP/UNICEF quotes: "full vaccination coverage for children 12-23 months".

NWFP and PAKISTAN: Aggregate figures for immunisation coverage as at FPHC are not available for NWFP or nationally. The WHO/UNICEF *Review* demonstrates that in Pakistan as a whole from 1980-2002 there were wide discrepancies between rates for BCG, DPT, Polio and Measles vaccinations, and discrepancies between what was reported to WHO, what was reported to UNICEF, and GOP's own estimates, shown in the ranges in the table above.

Comment on MCH data at ARC/PHC/FPHC

Although ARC Annual Reports record efforts from the earliest years to provide MCH, these years were marked by "pill-medicine". The three veteran members of staff interviewed said that there had been "a little" cholera, but no Annual Report mentions this. The early Reports record that TB was a serious problem, a priority for treatment in crowded camp conditions. Much energy went into case-finding via home visits, and pursuing defaulters to ensure that they completed courses of medication. The 1985 Annual Report records a total of 67 patients newly diagnosed or under treatment for pulmonary TB, plus another 7 extra-pulmonary cases (ARC Annual Report 1985: 18), but by 1990 the overall total under treatment was 11 (ARC/PHC Annual Report: 22).²⁵ Malaria was also a problem requiring energetic control measures such as spraying of houses with malathion and infill of stagnant water sites, as well as individual diagnoses and treatment.

²⁵ 12 patients were under treatment or surveillance in 1995 (FPHC AR 1995: 11). 28 patients were under treatment at the end of 2000, probably mostly from the village population (FPHC AR 2000: 21).

The consolidation of the health project in its second 1985-1989 phase when it settled in fixed BHUs, acquired more paid staff and strengthened its volunteer cohorts, combined with nutrition supplements, immunisation, (including TT for mothers) enabled the development of the MCH programme as TB and malaria control required less input. Ration issues to camps via UNHCR were finally phased out in 1992/3; regular milk distribution was also discontinued, though occasionally there was an unexpected donation of protein biscuits or dried skim milk (one of each arrived during my term as Administrator). In spite of reduced nutritional benefits, which might be expected to affect health standards, and introduction of the patient contribution in 1995, health status of camp people was at least maintained, according to the tables above. In 2000, because it still compared favourably with NWFP and Pakistan figures, it can be argued that this was due to ARC/PHC/FPHC's health activities. In 2000, FPHC's impact on villagers appeared to be increasing, but the picture remained unclear.

Although it has not been possible to locate comparable Afghan Refugee Health Programme data in series, the UNHCR/UNFPA Report 1999-2000 *"Improving Reproductive Health of Afghan people living in refugee villages in Pakistan"* (draft, unpaginated) claims that its Safe Motherhood Programme had achieved antenatal coverage of 80%, crediting *"all implementing partners"* with 70%, complete coverage being defined as three or more antenatal visits. 70% was also the figure claimed for supervised deliveries, 20% by MOs or LHVs and 50% by trained TBAs. The Programme claims post-natal coverage of 50% within three days, to include *"counselling on and provision of contraceptive methods that are appropriate for lactating mothers"* (Rehman 2001: 1.1,6).

SECTION C: FAMILY PLANNING

Family planning in Pakistan—qualitative and quantitative data.

After partition in 1947, when the population of Pakistan was about 50 million, concern about probable over-population culminated in the formation of the Family Planning Association of Pakistan (FPAP) in 1953. It is still active, claiming the role of pioneer and catalyst, advocate and service-delivery NGO (FPAP 2004:1). GOP itself was one of the first South Asian governments to launch a government-sponsored family planning programme, but

“Pakistan is exceptional in the region for its poor performance in improving contraceptive prevalence” (Fikree et al.2001: 130)

The situation in the years 1980-2000 is summarised in Table 9.9 below, together with contraceptive prevalence rates (CPR) in approximately corresponding periods. CPR is defined as

“The percentage of married women (including women in union) ages 15?49 who are using, or whose partners are using,, any form of contraception, whether modern or traditional” (UNDP: 2004).²⁶

Table 9.10	Pakistan Population Numbers (millions)	Contraceptive Prevalence rate (CPR)
1980	82.2m	6%
1985	96.2m	11%
1990	112.4m)	14%
1995	129.9m)	
2000	141.3m	24%

Sources: for 1980, WDR, figure relates to 1979; for 1985, WDR 1987: for 1990 and 1995, WDR 1997, figure relates to 1989-96
for 2000, HDR 2003:3, figures relate to 1995-2000

The continuing increase in population is an important factor in GOP's failure to provide universal basic health care, as explained in chapter 4: improvements have been unable to keep up with rising numbers. The table demonstrates that the rate of contraceptive use remains low: the problems of too many children born to too many young and under-nourished mothers persist along with the population.

²⁶ UNDP's question mark means that the actual age range covered may vary across countries; the reference to women in union includes non-marital partnerships. In Pakistan the parameters are taken to be 15-49; non-marital partnerships are illegal. In Pathan culture a girl suspected of an illicit relationship is likely to be shot by her father.

Dr. Shaheen Sardar Ali, the Provincial Health Minister, understood from her many field visits the lack of effective implementation of family planning, saying there was "*a dire need for focus*". Contraception had become unhelpfully associated with religion, but she conceded that an Islamic justification for family limitation is needed in a Muslim society. She was arranging meetings with religious leaders in order to re-orient discussion towards health issues. Quoting Iran, Egypt and Indonesia as examples of Muslim countries having permissive edicts in favour of family planning, she considered it was therefore possible to work out an acceptable family planning policy and practice for Pakistan.

The Health Minister cited Omran's *"Family Planning and the Legacy of Islam"* (1994 reprint). In his Introduction, he explains that the book "*avoids conclusions that favour one argument above another*" (i.e. either for or against family planning). Islamic scholars have written about it over the centuries, long before population pressures became a concern. His working definition of family planning indicates a regard for marital and parental responsibilities, regulating fertility with a view to warding off economic, social and health hardships. No verse in the Qur'an forbids spacing or reducing the number of pregnancies: his book interprets this absence as permissive (Omran 1994: 1,4,85).

Special considerations in NWFP

The religious issues which troubled the Minister and which may be invoked by ordinary Pakistanis against contraception—"everything is from Allah"; "*it is against Islam*"; "*you are not a good Muslim*"²⁷ are not the only influences on family planning. In NWFP and associated territories (including eastern Afghanistan) which assert their Islamic culture (sometimes their Islamic governments as well), there is not one culture but two, the other being Pathan culture. The local psychiatrist in Mardan, himself a Pathan, was very aware of the two cultural threads (MMP Journal). They are tightly interwoven, so that practices and traditions may be ascribed to Islam which may not be Islamic, but pre-date Islam. Veiling and *purdah* have no Koranic base. Sir Olaf Caroe, the last British Governor of NWFP, remarks in *"The Pathans"*

"Again and again, when moving in what may be called the Iranian world, I have been struck by the conviction that the influence of Persia all over these lands is a much deeper, older thing than anything which springs from Islam" (Caroe 1992 reprint: 26)

²⁷ These are typical remarks made by both camp and village women. The Mardan District Depute EDO (Health) was highly sceptical of the popular religious arguments against contraception: "*Islam is a religion of peace and honesty; but that doesn't stop them fighting and thieving.. Why then do they invoke Islam to reject family planning?*"

Dr. Emel Khan pointed out that the birth rate among non-refugee Pathans and Baluchis is higher than the Pakistan national average. He thought this "*an ethnic minority thing—a Pathan thing, and Baluchi too*" in response to numerical and political domination of Pakistan by Punjabis. The 1999 Annual Report of the Social Development and Policy Centre (Karachi) quotes the 1994 natural growth rate for rural NWFP as 3.4%, and 3.2% for Baluchistan, against 2.9% for rural Pakistan as a whole (SPDC Annual Report 1999: 153).

Policy and practicalities

Family planning is quite well publicised in Pakistan, especially in urban areas or on main roads by means of hoardings with painted slogans:

"The small family is the prosperous family" (seen near Islamabad airport)

"Welcome to the dish²⁸ of family planning" (*sic*—displayed at Attock on the NWFP side of the River Indus)

but such exhortations are unlikely to penetrate poor, largely illiterate conservative remote rural areas, and given chronic communication, supply and staffing problems, access to advice and methods must be erratic at best. GOP BHUs I visited (none remote) averred that they made available four standard methods of contraception, i.e. IUD, pills, injections and referral for tubal ligation, but interviews and records showed low uptake—single figures²⁹. Village women's groups entered readily into discussing contraception. For older women child-bearing seemed to have been a case of "*everything comes from God*" but one older woman had been sterilised on medical grounds, and was vociferous in her relief at her improved health and end of anxiety. Male patient groups on the other hand tended to be self-conscious and/or jocular in discussing it. They knew of it, but one village man said it was "*against our traditions*". Village men considered 4-5 children was a good family size, but many of them had in fact more. Younger unmarried men and women occasionally ventured that smaller families might be a good idea, and that they might seek advice in due course.

Many superstitious stories circulated in the villages about dire consequences of contraception,³⁰ but there was evidence from women of justified concern (sometimes on behalf of family members) about side-effects such as headaches and weight gain. There was also some fear of infection associated with surgical technique. This may be connected with

²⁸ Presumably this is intended for *desh* i.e. land

²⁹ All 6 women in the Swabi GOP BHU patient group said they used contraception; this BHU appeared atypical (see chapter 6).

³⁰ *Example 1*: a sterilised woman left her three children alone and returned to find them all dead. They had shut themselves in a chest while playing and been unable to open the lid. *Example 2*: a couple who had been using contraception decided to have another child. The wife gave birth to twins—"so you see, that's what happens".

stories or experiences of abortion, which is widely practised in Pakistan, though illegal, except when the health of the mother is at risk (GOP2000/1: ch. 3.7).

At FPHC, staff were very aware that contraception remained a delicate subject, and habitually used the phrase "*family spacing*" in discussion with village patients, for whom limitation was not an acceptable idea. Staff also knew that husbands, if they could afford it, did not usually object to an abortion (by a private practitioner)³¹ if an unwanted pregnancy occurred, though they had not allowed the use of contraception. FPHC's own practice at Wardaga HC (following training in counselling methods) was to involve the husband if contraception was being considered, enlisting help from male CHWs if necessary. Husbands were liable to react fiercely if it was used without their knowledge. The four methods— injections, pills, IUD (copper T only) and referral for tubal ligation—were practised. But if a husband refused to discuss contraception, and there was a medical justification, staff would prescribe —"*it is her life*", said the team LHV. At one GOP BHU where a number of village men worked abroad (usually in Saudi Arabia), the LHV said that wives requested an injection when husbands were due their three-months' leave. BHU staff obliged; there was no consultation with the couple.

Family planning and the refugee population

Senior officials of both UNHCR and GOP from the Health Minister downwards all declared that the refugee reproduction rate was higher than among Pakistanis. Though my samples are very small this assertion was borne out in 2001: the average number of children for the village patient groups interviewed was 5.2, for refugee groups 7.5. McGinn et al. (2001: 15) quote 6 as the mean number of children in Afghan refugee families in their study, but admit their sample of women (716) was small in relation to the total number of women in the camps. Health data for Afghanistan are even less likely to be reliable than those for Pakistan, but as a country for many years at the lowest end of the HDI "*least developed countries*" it is probable that the IMR and MMR were worse, certainly for rural areas, further disincentives to practising contraception. Becoming refugees in another country while fighting continued in their own possibly reinforced a perceived need for population replacement—perhaps warrior replacement if the fighting was prolonged. The Health Minister labelled the unwillingness of Afghans in Pakistan to practise contraception "*a response by a society in distress and strife*".

³¹ GOP has no facilities for therapeutic abortion, but Marie Stopes International has been active in Pakistan for some time and has a clinic in Peshawar. FPHC does not practise termination. In Mardan there is a "lady doctor" with an allegedly lucrative abortion practice, but FPHC staff believed she was not medically qualified.

The Programme Officer (Health) of UNHCR in Islamabad agreed with the higher refugee birth rate, but said there was no accurate figure. She attributed an alleged refugee IMR of 32-33 in year 2000 to under-reporting, quoting a figure of 59 from a 1992 survey (details not specified). A reduction to nearly half within eight years she thought improbable. The need to increase contraceptive use among the refugees was not in doubt, but it was extremely difficult. It was not until 1996, when the Afghans had been in Pakistan for over 15 years, that the Refugee Health Programme had felt sufficiently confident to promote it. Even then the advice was to proceed very cautiously and carefully, she said. The Depute Project Director (Health) of the Refugee Health Programme estimated refugee CPR at 4%. Dr. Emel Khan stressed potential reaction from camp *mullahs*—the vociferous, influential and conservative clergy. But the ARC/PHC Annual Report 1991: 14 makes a brief mention of the possibility of discussing "*child spacing*" during post-natal home visits by female staff—ante-dating the Refugee Health Programme decision by some years.

Family planning: quantitative data—at ARC/PHC/FPHC

Throughout the 1990s in spite of the difficulties mentioned, there was a very gradual increase in contraceptive use among refugees in the three camps, and after 1995 an increase due most likely to uptake among village women, according to staff (see chart C9.1). This chart records the number of individual women in the programme, not number of attendances (confirmed by Director FPHC 31.03.04).

Although the chart does not differentiate between refugees and non-refugees, the 1992, 1993 and 1994 figures relate only to ARC/PHC's refugee service, as it then was. The small figure for 1992 applies also to 1991: staff quoted it to MMP/JSP in 1991, although there is no mention of actual numbers in the Annual Report for that year. The increase in use for camp women 1991-1994 is roughly 500% over three years. The 1995 figure includes village women, showing an increase in one year of over 250% (302 to 762 users). This accords with staff opinion that uptake was greater among villagers than among camp women. However, throughout this period, the statistics do not differentiate between new recruits and returnees, that is, women who chose to drop out of the FP programme to have another child and re-entered the programme later.

Chart C9.1: Women in ARC/PHC/FPHC Family Planning Programme 1992-2000

Source: compilation from ARC/PHC/FPHC Annual Reports 1992-2000

According to calculations based on FPHC's data, out of a total patient population of 100,000 in 1999, women of child-bearing age (CBAs) comprised about 21,000. FPHC's Annual Report of 2000 gives the number of contraceptive users in 1999 as 1899. Supposing they are treated for calculation purposes as all new users, the table indicates a user rate of 9.04%. Even without disaggregation between refugees and non-refugees it appears an improvement, albeit very slow, from the situation in 1991, when contraception was reportedly used only for medical reasons for a very few women, and not for its primary purpose. Prescribing practice partly depends on supplies coming from FPAP and UNHCR.³² However, it is not possible to discover the number of "protected years" from these data. The concept is perhaps overly sophisticated for the circumstances of FPHC; the data as shown above may lend itself to distorted or exaggerated interpretation.

From the new *Health Information System (HIS) Consolidated Report: July 2002*, it is possible to estimate CPR rates for the Refugee Health Programme. This document lists figures from five Districts in which the Programme managed camp BHUs, and from 13 partner NGOs providing health care to camps. Rates range from 0% at two NGOs to 15%

³² "Pills are prescribed for one month only. Sometimes we get injection "Norgest" which protects for 2 months, sometimes we get Depo Provera which protects for 3 months" (personal communication from Director FPHC 31.3.04)

(the NGO Dar-us-Salam), with an average CPR of 2.24%. FPHC comes third in this "league table" at 4.5%. But the *UNHCR/UNFPA Project End Report* mentioned above (1999-2000, para 1.2, draft only) quotes FPHC as having a CPR of 16%. Reconciling these various figures is problematic. It is not clear how each of the many agencies (including FPHC) precisely define contraceptive prevalence, and figures may be affected by inconsistency of supplies. It is possible that FPHC's non-disaggregation of refugee/villager contraception figures may derive from recording instruments supplied by FPAP, which gave practical support to FPHC, providing educational matter, training six staff, and supplying contraceptives. FPAP had no interest in differentiating between refugees and villagers. This combination of uncertain criteria affecting data at many agencies means that "CPR" as an indicator is inconsistent and not really viable.

Even where interest and some degree of acceptance existed, FPHC staff did not consider it realistic in Pathan communities to talk in terms of numerical targets where attitudes remained so entrenched, especially among the refugees. The Annual Reports simply indicate a target of "*increase in the number of women in the programme*". Change in this component of PHC will take time, perhaps even more time than with other components, in a society where children remain an investment, for women the way to earn status, and where son preference prevails. The External Evaluation 2000 (Raza 2000: 22) notes that studies show more than five years are needed for lasting changes to take place. At the more conservative Gandaf camp the standard "*God's will*" attitude to child-bearing was evident, but some of the female patient group admitted using contraception.³³ My suggestion to this group that perhaps it was God who had enabled new knowledge produced a sudden silence, broken by one woman who said "*it is for good care of the children*", which no-one contradicted.

Contraception for men

Condoms are available in the bazaars, but quality is doubtful. They are available from FPHC Health Centres. In 2001 staff at Wardaga distributed some to wives, more in hope than in realistic expectation of use. There was no information on acceptance. GOP was in 2002 running television advertisements promoting family planning—one featured one of Pakistan's senior nuclear scientists who had undergone a vasectomy—but at FPHC even senior male staff were not sympathetic. In what is still a male-dominated society, family planning as practised at FPHC is very much female-oriented. An external criticism of FPHC came from TAF which funded Wardaga HC and also the newest HC at Ismaila village (which I did not

³³ One woman had just chosen to stop using it in order to start her ninth pregnancy.

visit). They considered that FPHC was rather inhibited about promoting contraception among men, but in fact health education groups for men had begun to include the topic.

Conclusions on the impact of PHC, MCH and Family Planning

Qualitative data indicated that introduction and potential impact of PHC on a target population required tactful management with due regard for cultural norms. Local research after 6-7 years of the CHW scheme pioneered by SCF (UK) demonstrated that selected trainees could capitalise on in-camp residence so as to be of real help in increasing effectiveness of BHU teams.

Training of CHWS and TBAs at ARC/PHC/FPHC was conceivably one factor in a dramatically reduced IMR and Under-5 MR, but immunisation, supplementary feeding and antenatal care were others in a constellation of influences. Refugees' behaviour in a settled community modified to a greater degree of acceptance; understanding of prevention increased, but slowly, because of persisting restrictions, mostly on women's involvement.

At ARC/PHC/FPHC there was significant impact on professional attitudes and work-style. This accords with recognition in the Alma Ata Declaration that this change is essential for PHC practice. Length of service, continuity and loyalty to the organisation by all levels of staff probably facilitated it. By 2000, similar attitudinal change did not appear to have been effectively promoted within either GOP's system or the Refugee Health Programme.

Some MCH data was chosen to assess impact on target populations, as recognised indicators of community health. The most dramatic effect was on the IMR and under-5 MR of the refugees in the middle ten years of the health project's functioning. Family Planning figures, at first a "blank" in health care, improved very gradually. While still not widely used, the rate is perhaps as good as can be expected, given the circumstances.

In spite of withdrawal of material benefits and imposition of charges, the improved health status of the refugee "demonstration population" appears to have been maintained. External Evaluations of 1998 and 2000 are generally positive but do not address quantifying in detail. Evidence for FPHC's progress in penetrating the villages is weaker, partly because of a lack of base data, particularly regarding numbers of pregnancies. Villagers had only the last five years of the 20-year period to attempt the level of behaviour modification achieved in the camps; newer volunteer health workers seemed not yet to appreciate accuracy in recording: significant impact takes time. However, contraceptive use appeared to be increasing more among villagers than in the camps, probably because of familiarity with GOP publicity,

though the GOP family planning programme has not itself been effective. In both target populations FPHC contraceptive policy is directed at women rather than men.

Senior UNHCR health staff, who were not able to promote contraception until the later 1990s (discussed at ARC/PHC some years earlier) considered that the refugees remained subject to pressures of displacement and a theoretically unsettled situation, not unconnected with the myth of return. Dr. Zamani, who had no intimate contact with the health project since 1991, surmised that one effect of the FPHC refugees' experience in Pakistan would be improved ability to specify requirements from a health service when they returned to Afghanistan, and to pursue their demands. But this must depend on a peaceful Afghanistan, a reasonably stable government, adequate finance, political will, and adoption of an appropriate health strategy, as well as people's ability to make their voices heard.

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CHAPTER 10

CONCLUSIONS AND LESSONS LEARNED

The overall aim of the case study is to assess whether, and if so, to describe and analyse the process by which, a health-oriented NGO (Frontier Primary Health Care) has moved from refugee medical relief to providing non-discriminatory health care for residents of a specific area, that is, people belonging to the host country as well as refugees, from its inception in 1980 to the year 2000.

The chapter starts with a clarification of the aim of the case study, and a reminder of the complexity of health care provision in NWFP. It addresses questions set out in chapter 1. It goes on to assess whether the research has met the aim of the study, and analyses factors influencing changes in the NGO's practices and remit over the twenty years 1980-2000. The chapter ends by drawing conclusions, identifying lessons learned, and raises some further questions.

Health care in NWFP— some clarifications, and a change of wording

The aim as stated does not specify the kind of "*health care*". FPHC and its immediate predecessor ARC/PHC claimed to operate a primary health care (PHC) service as outlined in the 1978 Declaration of Alma Ata. This claim helped to determine the research design. One of the questions in the design was not truly a research question, as explained in chapter 1: but describing what alternative services existed for refugees and for non-refugees helped to place the NGO FPHC in the context of health care provision in NWFP.

When I began the research, I was familiar with the NGO, and I assumed that UNHCR was the agency running BHUs for refugees in camps. During the research, I learned that UNHCR was not solely or directly responsible for health care for Afghans in Pakistan. UNHCR's involvement from January 1980 onwards was in response to GOP's request following the huge increase in refugee inflows. The Afghans' needs greatly outstripped GOP's earlier attempts at providing for them through its own health care system.

The solution was a partnership between UNHCR and GOP, an arrangement quite usual between UNHCR and host governments, leading to the creation of the Afghan Refugee Health Programme, separate from GOP's basic system. A similar partner relationship existed between UNHCR and individual NGOs providing health care for refugees. UNHCR consulted major international agencies, including WHO, which advised that the Refugee Health Programme should move towards PHC. At its in-country office in Islamabad, UNHCR retained oversight of the Refugee Health Programme.

These facts are basic to understanding the situation in NWFP. They also require a slight modification to a reference in the research questions: "*Afghan Refugee Health Programme*" replaces "*UNHCR*" in the original versions.

Research questions

1. *Which aspects of primary health care (PHC) were adopted at different stages by the Afghan Refugee Health Programme and FPHC, according to the definition of PHC as described in WHO's eight listed components in the Declaration of Alma Ata?*

UNHCR itself recognised safe water and basic sanitation in refugee camps as an immediate priority, using specialist NGOs as installing agents (see chapter 4). As PHC components include water and sanitation, UNHCR itself can be said to have initiated PHC before WHO recommended it as the appropriate strategy.

In its strategic role, the Refugee Health Programme promoted the doctor-led team for basic care in all camps; this was adopted at ARC. It was not possible to find precise evidence on when the Programme introduced each PHC component. However, ARC Annual Reports show that Dr. Zamani followed the Programme's lead as soon it made resources available. For example, the UNICEF/SCF CHW scheme started in 1982/3—Dr. Zamani trained the first batch of ARC CHWs in 1984. By this date, ARC was providing seven PHC components to its target refugee population, indicating the Programme's rapid progress.¹ ARC/PHC's inclusion of technical and administrative support to its teams, localised measures (not in themselves PHC features) facilitated promptness and efficiency in daily work. ARC/PHC teams were larger than those directly managed by the Refugee Programme from Peshawar. ARC/PHC was not confined by official Programme policy, as indicated by attempts in 1991 at discussing contraception with individual refugees well before the Programme ventured to address it in 1996, when it was still considered a sensitive topic among the Afghans (see chapter 9).

¹ ARC Annual Report 1984: 3

2. *How far over time did each organisation implement the “Three Pillars” of primary health care (participation, inter-sectoral collaboration and equity)?*

Chapters 6,7 and 8 examined this in detail. Available data indicated that in the **Refugee Health Programme, participation** as patients in need was probably general except for some cultural inhibition. The characteristic **participatory feature** of the Programme, training volunteer workers, was present in 2002, but there seemed to be no community involvement beyond this. The training of doctors (nearly all Pakistani) for Programme BHUs was confined to basic PHC components. A wider understanding of strategy and principles would educate health professionals and help Programme development. As Benatar says:

“improving the health of populations will require profound social, economic, political and cultural changes...health care professionals are challenged to broaden their understanding of health, disease, suffering and of their role in society” (1997: 1635)

The Programme demonstrated **inter-sectoral collaboration**: between GOP and UNHCR, and with other global agencies. As a *de facto* discrete sector within NWFP (see chapter 7) the Programme’s partnerships with NGOs exemplify **intra-sectoral collaboration**.

Cross-over points with GOP–Pakistani personnel, hospital referral and reciprocal BHU use—are not true **inter-sectoral collaboration** but practical arrangements in what was originally expected to be a temporary situation, with a nod towards **equity**. The two parallel systems remained officially separate, administratively and in content.² The Programme’s PHC policy demonstrated an **equitable** aim for camp populations. Services at its own BHUs were free, but there were hints that problems of supplies, maintenance and staff attendance affected **equity**. Providing lady doctors at Programme BHUs and 24/7 labour rooms at selected locations had the **equitable aim** of countering gender bias. However, research by Bartlett et al. (2002: 643-649) in the Hangu area of NWFP like that by Hafeez et al. (footnote 2 below) confirms that pregnancy and motherhood continued to carry high risks for camp women. The Programme made pro-active efforts, as in its 1999-2000 draft Report *“Improving Reproductive Health of Afghan people living in refugee villages in Pakistan”*, sponsored by UNHCR/UNFP (Rehman 1999-2000). I found no evidence of researchers (Godfrey excepted) or GOP seeking to learn from the Programme’s long experience in PHC.

² Recent independent research claims that secondary level care (i.e. in GOP hospitals) for refugees and for local people is poorly integrated and seriously unsatisfactory, especially for mothers and babies from both populations (Hafeez et al: 2004: 834-836). It blames inadequate training and limited availability of hospital staff, lack of specialists, poor transport facilities, camp conditions, and poorly trained or untrained health workers in villages. The camps studied in this research are very large, re-opened to cope with the “drought” influx. Conditions and services were probably worse than in older settled camps. The comments on the hospitals agree with criticisms of GOP provision in general. For an account of FPHC’s approach to the problem of secondary care, see the annex on FPHC’s post-2000 activities.

Chapters 6,7 and 8 underlined the shortcomings of **GOP's basic care system**. I found no evidence of the "Three Pillars" beyond passive **participation** by patients.

Chapter 6 provides detailed evidence of **FPHC's** adoption of a **participative** work-style. Community involvement had progressed so far by 2000 that patients contributed to planning and made criticisms amounting to informal evaluation. This appeared far in advance of the other two services. **Inter-sectoral collaboration** was less evident, but from the early 1980s ARC/PHC/PHC demonstrated a holistic attitude to health. Early **collaboration** with specialist NGOs was followed by growing interest by GOP's Provincial Health Department. The non-discriminatory extension of FPHC's work into the villages was essentially **equitable**, but apart from the gradualism of uptake by villagers (an expected feature of expansion) new policy and practice is not totally **equitable**, because refugees benefit from long-established water and sanitation installations. In the absence of GOP provision, FPHC could explore ways of making up this deficit, e.g. by involving a specialist NGO.

In 2001, management considered that entrenched cultural attitudes inhibited discussion of gender beyond training of staff: this aspect of **equity** was still a sensitive topic.

Introducing user charges may **compromise equity**, if PHC is "*Health for All*" as a human right. More detailed research would be needed to discover whether FPHC patients had been deterred by cost: some people were poorer than others. A "customer" relationship may drive a demand for additional and varied services; pressure by patients (like pressure by donors) on the organisation may distort its aims. Expectations tend to rise as basic health improves and the constituency becomes more articulate, as has happened in the UK NHS .

3. *What impact has each organisation (i.e. GOP, the Refugee Health Programme and FPHC) had on the health of communities?*

The disadvantaged position of the rural poor, dependent on **GOP's** system, has been well documented by researchers expatriate and indigenous. Improvements in health indicators have been largely offset by rapid population increase. Conservative cultural attitudes in NWFP are inhibiting influences additional to difficulties in accessing family planning services.

Quantitative data for the **Refugee Health Programme** were difficult to obtain, and even basic population figures, according to UNHCR itself, are approximate. Yet in general the camp population probably experienced a higher standard of health care from the Programme than they had in rural Afghanistan. Refugees' willingness to volunteer for training as health workers is evidence of early Programme impact. Figures for contraception among refugees

are inconsistent—perhaps Depute Project Director Health’s educated guess in 2001 of an overall prevalence of 4% is a reasonable approximation.

Qualitative data from **FPHC** indicated a high rate of uptake by refugees, based on the close relationship with the health project forged over many years. The most striking quantitative evidence of impact on the camp population was the decrease in the Infant Mortality Rate and the Under-5 Mortality Rate in the middle ten years of the health project’s life, 1984-1994.

By 2000, FPHC had worked in the villages for five years, compared with over 14 years in the camps at the time of the 1995 expansion into the villages. Rate of uptake by villagers was increasing, but the lack of base data in the villages renders a precise assessment of impact difficult. In 2001, villagers seemed more likely to be converted to “family spacing” than camp residents, possibly because of GOP’s publicising of its long-standing but ineffectual family planning programme. However, Robertson et al. discussing quantitative data as measures of effectiveness and efficiency in humanitarian interventions advise

“it is important not to mistake the absence of evidence as evidence for the absence of effectiveness or efficiency” (2002: 330).

Hopefully FPHC will increase penetration of villages. FPHC staff showed optimism, patience, persistence and appreciation that lasting change takes a long time.

Has the research met the aim of the case study?

Chapter 3 shows that **this health-oriented project has indeed moved from medical relief for a group of refugees to providing health care for local villagers, as well as continuing to serve the original refugee target population.** Fieldwork interviews in 2001 with groups of registered patients both male and female from camps and villages confirmed that both populations, refugees and non-refugees, made use of FPHC’s service available from its six Health Centres, three in camps and three in villages. Both groups perceived FPHC as providing more than medical relief and curative care and appreciated that the service emphasised prevention. Both groups had access to seven of the eight components of PHC: in addition, the refugees had access to safe water and sanitation, but neither of these was available to all villagers.

The second part of the aim is *“the description and analysis of the process”* by which the move has been effected. Chapter 3 provided a historical account of the process, but analysis requires special consideration of the last research question:

What factors have influenced changes in FPHC's practices and remit 1980-2000?

Some factors are present throughout all four of the NGO's developmental phases described in chapter 3, others have assumed greater or lesser significance at different times.

From the start and throughout the twenty years, **Austrian support of the health work was of prime significance**. It was an immediate international response to need. Regular annual funding in the form of a block grant enabled flexibility. Austrian finance also provided for several overseas professional courses and supported the work necessary for transition to independent identity. The **Afghan Refugee Health Programme** was another constant, as mentor/promoter of the PHC strategy to NGO partners in the Programme, and as channel for material resources from UNHCR.

Leadership was of crucial initial importance. Chapter 6 explained that PHC literature does not pay much attention to the topic. But Dr. Zamani's exceptional ability and industry was fundamental in structuring and consolidating the health project. He built multi-skilled teams, and initiated community participation by training volunteer workers. **Active learning**, using in-service, refresher and external courses persisted as characteristic of all staff grades.

Use of **external consultants** was also a constant, in that it occurred throughout the twenty years. However, visits were intermittent and time-limited, but long enough for consultants to produce reports based on observation and comparison with other agencies. Medium-term consultancy was an antidote to possible dominance: **staff were entirely indigenous**—nearly all Afghans, apart from a few who were Pakistani nationals, but also Pathan.

The health project's gradual semi-detachment from ARC's Peshawar office was partly due to the practical need for a **local office**, and partly because the work was confined to a clearly **boundaried population apparently settled** in Pakistan, in contrast to other ARC projects. The **spontaneous behaviour of villagers** at Kagan in opting for health care by ARC/PHC fostered a relationship with non-refugee local people, laying a foundation for future redirection.

Following the closure of ARC in the early 1990s, **constructive recommendations by external evaluators**, together with **support from MMP and JSP** (for a longer period than other consultants) combined to secure a sound policy and administrative base for the survival and extension of the health work. The newly constituted NGO declared a non-discriminatory aim of serving non-refugee villagers in the area as well as the original refugee group.

Even before the new NGO became a legal entity, an internal promotion ensured **continuity of leadership**. Its style changed significantly with the personality of the leader (or as it became, a joint husband and wife leadership). Delegation, decentralisation, using group methods for assessing needs, promoting health education, involving women, and extending communication beyond elders to community groups, all combined to **increase participation by the community**. The transition to independent NGO status enabled FPHC to **control its own resources**, and to **retain human and material assets** for service to an increased target population. Some finance continued from Austria, but the new NGO had to enter a competitive market; it also introduced small charges for patients attending Health Centres. FPHC's quest for income had a positive side, because it forged **wider relationships** with potential donors including GOP. FPHC's positive response to requests from other local communities to train health workers suggested another developmental path.

Lessons learned

Firstly, this case study provides an example of Comprehensive Primary Health Care as a feasible and effective way of providing basic health care in a developing country.

Secondly, it demonstrates that an NGO can be a competent agency to do so.

Thirdly, it provides an example of refugees making a contribution to basic welfare in a host country, not as individuals entering the labour market (though some of ARC/PHC/FPHC's patients have done so) but on an organisational level: from the start, the health project was managed and largely staffed by refugees. It became a bridge between two communities, partly because the host community, the local villagers, sought help and received it.

Wider ramifications

Perceptions of refugees

While the factors above are specific to this health project, some relate to wider bodies of knowledge about refugees, host countries, and NGOs. In her paper *"The role and impact of humanitarian assets in refugee-hosting countries"* Phillips chooses to assess *"refugee-related assets"* on the grounds that these are quantifiable³. Research on refugee impact on hosts has tended to concentrate on the environment, refugees being perceived as a burden, she says. Few questions are asked about what happens to the tangible assets put in place by UNHCR via procurement, such as schools, hospitals, vehicles and equipment, when camps are closed or refugees repatriate. In 1993, of UNHCR's \$250 million assets, only 20%

³ "although regretfully the available information is not comprehensive", she admits.

was recorded at UNHCR headquarters, leaving 80% unaccounted for (Phillips 2003: 7-8). Formal arrangements for disposal, donation, and transfer of ownership face difficulties of decision-making at field level as assets are often not returned and fights can break out among local people who had expectations⁴. She suggests on the other hand that hosts may sometimes be landed with things they do not really want, perhaps costly to maintain. She argues for transfer not to international NGOs who are likely to withdraw after an operation, but to “*local actors and NGOs*”, and emphasises the need for tactful and sensitive negotiations, especially at the time of repatriations, for the benefit of host communities. She includes among assets “*less tangible input such as skills and knowledge transfer*”. FPHC’s transformation to an indigenous identity appears to have anticipated and surmounted some of these problems. Though not free from anxiety, pain and threat, the process effected ultimately peaceable transfer of material assets—buildings, vehicles and equipment, as well as staff knowledge and skills. Some of these skills were invested in local capacity-building through training village volunteers and galvanising community action. Where primary health care is concerned, these Afghan refugees are not a burden: they have contributed to welfare in a specific area of the host country, persisting beyond the twenty years of this case study. I have found no similar example in Pakistan of a formally declared policy of non-discriminatory PHC.

NGOs and learning

According to Britton

“a strong case has been established for the importance of learning as a means of improving organisational effectiveness even against the background of considerable change and unpredictability” (1998: 2).

In searching for a definition of “*the learning organisation*”, he quotes Pedler’s:

“an organisation that facilitates the learning of all its members and continuously transforms itself”.

and goes on to quote one specifically written with not-for-profit organisations in mind:

“An organisation which actively incorporates the experience and knowledge of its members and partners through the development of practices, policies procedures and systems in ways which continuously improve its ability to set and achieve goals, satisfy stakeholders, develop its practice, value and develop its people and achieve its mission with its constituency” (Britton 1998:3, quoting Aiken and Britton 1997)

⁴ During the 1990s it was notorious in NWFP that any supplies or vehicles going into Afghanistan (including ARC’s) were at serious risk of not reaching the delivery address or not coming back, or both.

In my opinion, FPHC qualifies as a learning organisation according to this definition. Its stress on learning by staff at all levels, training volunteers, its regular use of procedures and systems to implement its declared policies contributed to its success in achieving its mission. In general, patients expressed positive views, while staff recognised that the mission is an ongoing exercise. Britton quotes Pearn as emphasising the *process* of organisational learning rather than the *state* of being a learning organisation (1998: 3). A long-serving Master Trainer at FPHC volunteered that

“my work is never ignored, it is always appreciated, and there are chances for more learning”.

Dr. Emel Khan said in 2001

“the challenge increases; it is not now just day-to-day management—there are different kinds of problems, the organisation is in a new phase”.

A senior member of CIDA staff commented in 2001 that FPHC has moved with the times. Time itself is an important consideration in primary health care strategy:

“Large inputs of resources channelled too rapidly into the community from outside can impair a community’s capacity for sustained development. The commodity needed most is time—time to overcome human apathy and despair after generations of poverty, oppression and war” (Jareg and Kaseje 1998: 5)

Learning has another aspect. Some writers criticise NGOs as inclined to emphasise their successes to the point of getting lost in self-admiration (Madeley 1999: 110; Thin 1997: 4-5). Positive messages are more likely to attract donors, but learning from mistakes and learning from each other is too often forgotten (Clark 1991: 12). The health project weathered change and unpredictability to become a dynamic organisation planning further developments from 2000. Leadership has been important, but different personalities brought in a new leadership style, showing that continuity does not mean no change, but a style appropriate at a particular juncture. Risks have been taken: Early Education and Mental Health initiatives have fallen, the Medicine Bank has not been as successful as hoped, but broadly speaking, in year 2000 FPHC was an effectively functioning primary health care organisation, as it is in 2004, according to current communication with the Director.

Since year 2000, there is a new organisation in Peshawar “*Frontier Resource Centre*” which aims to collect information on NGOs and CBOs in NWFP. This appears to be a first step towards a Directory; there is a monthly Newsletter and an intention to provide support and training. Perhaps this might become a forum for NGOs to share and learn as suggested above. But it would require attitudinal change on the part of many NGOs, who are not noted for co-operative behaviour, as the Director of ACBAR emphasised (see chapter 5).

Ethical components

Macdonald says that equity has a moral component. I believe that a moral component contributed to the health project's survival and development into the new NGO. At a critical time, it would have been understandable if staff chose to leave when financial advantage allowed, thus putting the organisation, the service, and patients at risk. Instead I witnessed in 1994 and 1995 widespread staff loyalty and commitment (not without some pain and anxiety) to a belief in PHC and the health project, based on their experience. Throughout the twenty years, the leadership has consistently shown dedication to the work. The importance of these and similar non-measurable factors is recognised in a recent article (Berwick 2004: 1124-1129) mentioning

"a combination of intensity, cleverness, hard work and optimism needed for change in developing countries to go well"—all of which were evident at FPHC.

Limitations and questions arising from the case study

FPHC demonstrated characteristics of NGOs mentioned in the literature, such as closeness to the people (observed over many years and during fieldwork), and close relationships between management and all grades of staff and volunteers, facilitating supportive supervision and learning. But as an NGO its influence and activities may be restricted:

"an NGO on its own can never hope to benefit more than a few favoured localities" (Korten 1990: 120).

Expansion has been possible, notably in response to local demand, so that the target population has increased twice over, but this does not invalidate Korten's comment, nor one by a member of CIDA staff—*"FPHC is very good for those it reaches"*. Even if uptake by the newer cohort is increasing, FPHC is still essentially a local organisation. Key suggested that "entrepreneurial" NGOs can sometimes progress to his "insider" category. Whether FPHC's emerging relationships with GOP personnel will enable this, or why and how it might be a positive, needs more time for proper assessment.

Can FPHC's work be extended?

The question arises as to how possible it is to extend the work or increase the influence of an organisation such as FPHC. Britton (not writing specifically about health NGOs) suggests three optional strategies: additive, multiplicative and diffusive.

Additive:

Increase the size of the organisation e.g. by adding programmes or setting up more Health Centres under the same management. But FPHC's comparatively small size and geographical boundaries have been influential in its effectiveness. Adding more programmes might mean moving towards "*integrated rural development*". However, Madeley advises that multi-objective projects of this type seldom produce benefits because of insufficient administrative capacity or inadequate skills infrastructure (1995: 13). The latter was FPHC's reason for rejecting the route of rural development (see chapter 3). The evaluators did not pursue this in 1998, having accepted that FPHC functioned as an integrated service-delivery health project. Perhaps FPHC could add other health programmes, which in fact it has done after year 2000 (see annex).

Multiplicative:

Achieve impact through deliberate influence, policy change, legal reform, or training and consultancy. This is already a reality: becoming a new legal entity and changing its policy have facilitated FPHC's growth and influence. Training and consultancy was quite well established at FPHC by 2000, by providing CHW courses and "technical support" for CBOs wishing to improve local health care. This has the advantage of costing FPHC very little: CBOs provided short-term hospitality as needed—perhaps FPHC could gather some income from this service.

Diffusive:

Spread ideas informally and spontaneously. If a strategy is a deliberate plan, this hardly qualifies as a strategy, and probably depends on the local cultural climate and whether it provides opportunities for networking.

Is replication an option?

Theoretically it seems possible, so long as:

- Leaders and trainers are strongly motivated by a belief in PHC (to which they may have to be converted) including its underlying principles
- Aims are clear and target population numbers realistic
- Income and material resources are adequate and dependable
- Maximum use is made of indigenous staff at all organisational levels
- Administrative back-up is efficient; there is delegation, decentralisation and supportive supervision
- Managers believe in the capacity of people in the community, even if illiterate
- All grades of staff have access to learning opportunities; external advice and consultancy is short-term and limited
- There is sensitivity to cultural norms affecting staff and patients: change takes time

If these conditions were met, replication of this doctor-led team-based PHC model appears a possibility, preferable to further expansion—maybe on a sort of “franchise” basis, and limited to NWFP. FPHC could provide guidance and close supervision at least in the beginning. But there is a risk that chronic problems like absenteeism and lack of accountability—apparently endemic throughout Pakistan—might arise. And there is the problem of serving remote areas, of which FPHC has no real experience.

Is FPHC itself sustainable?

FPHC has been throughout its existence largely dependent on donors external to Pakistan; even the SAP/PDP funds came from international sources. If external funding were to be withdrawn, the FPHC service (and many other NGO ventures, not only in health) would be at risk of collapse. FPHC’s “patient contribution” is never likely to be sufficient to fund the service: the literature acknowledges that health care for the poor cannot be adequately funded by them. The Declaration of Alma Ata laid the responsibility for health care on governments, but there seems little reason to be optimistic about GOP as a universal provider given its history and its ongoing political insecurities. It looks as if external donors will be required for the foreseeable future.

The problem is neatly summarised by Green and Matthias. They discuss various options such as different types of community financing (which may put equity at risk), or charging other organisations for services (are they any more able to pay than patients?) or obtaining government contracts to serve a specific area (which may threaten NGO autonomy). In the end, they say, the problem for donors is to find a mechanism for funding which does not change the nature of the NGO in the process (1997: 128-131). Donors and NGOs have to wrestle with this considerable difficulty: they must recognise that open-ended programme funding is different from time-limited project funding, and particularly in health care, is an ongoing need.

In the meantime, whether donors are motivated by contemporary political considerations, by humanitarianism or by post-colonial guilt, their support and funding can make a contribution to feasible solutions. These may be local, on a relatively small scale, or dispersed. That, however, is not an argument against efforts to reduce global discrepancies between rich and poor, nor against initiatives aiming to heighten awareness of governments and people in general about the need to redress the balance between developing and industrialised countries in today’s world.

Chapter 10 References

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Annexes

1. **The volunteer couple**
2. **List of interviewees**
3. **Samples of interview prompts**
4. **Five research questions: five charts**
5. **FPHC after year 2000**

The volunteer couple, their background and the placement

Scotland

By the late 1980s MMP and JSP had both attained retirement age, but were still in employment. JSP acted as a part-time medical referee for the Dept. of Health and Social Security, and MMP worked full-time but on a series of temporary contracts with Lothian Region/Edinburgh Council Social Work Department, on administrative projects concerning professional practice. Being free of family responsibilities, in good health, and aware that VSO had become interested in older candidates, we applied to become volunteers, on the basis of our extensive professional experience.

JSP as a general medical practitioner had worked in many different settings—county town, mining towns, rural areas including three years single-handed in the isolated situation of one of the larger Orkney islands, and lastly in the capital city. From there he became a Regional Medical Officer and finally a Senior Medical Officer in the Scottish Home and Health Department, with a range of administrative and geographical responsibilities. He had some overseas (non-medical) experience during his years in the army (1942-1946).

MMP had trained and worked as a teacher after graduation, later adding a basic qualification in social work. After marriage in 1950, family and domestic responsibilities in the various locations prevented return to work and study to update qualifications until 1968. Work experience thereafter was mostly in the local authority Social Work Department at different levels, apart from five years as Project Leader and Professional Assistant in a voluntary organisation. Committee and counselling work for other voluntary and statutory groups had been fitted in during the child-rearing years. MMP had not worked overseas, but managing a professional and family household in a remote island with neither electricity nor a gravitational water supply was a kind of apprenticeship for VSO.

Pakistan

VSO treated MMP as the lead applicant. If jobs for both partners could not be arranged in advance, a man would have a better chance than a woman of picking up work, once in-country, when a Muslim society was being considered for placement. This was especially relevant in Mardan, reported to be a conservative area, more so than North West Frontier Province in general. In response to the health project's request for an Administrator, VSO

therefore chose to place MMP, in the expectation that JSP as a doctor would find occupation in due course.

The Medical Co-ordinator/Director of the Austrian Relief Committee for Afghans (ARC) was attending a management course in The Netherlands when we arrived in Pakistan in August 1991. Three weeks after his return to Mardan in October, he was badly shot up in an assassination attempt. The Austrian Embassy immediately arranged a flight to Vienna, where he and his wife remained for over a year, undergoing extensive surgery. A long period of uncertainty ensued, for the health project and for staff in the Main Office of ARC in Peshawar, as recounted in Chapter 3. Six months elapsed before an Acting Medical Co-ordinator was appointed—a Pakistani doctor already on the health project staff.

In the hiatus, MMP and JSP in effect carried responsibility for oversight of the health project. There was no senior medical person anywhere in the entire ARC organisation. JSP stepped into the breach as Medical Adviser, doing no clinical work but available to staff for consultation, and undertaking tasks such as the revision of the drugs list and some epidemiology. MMP's role as Administrator enabled her to function as Project Manager. Delegation had not been a feature of the previous leadership, but in our joint opinion there were several people on both the professional and administrative sides who were capable of assuming responsibility. Our role moved in the direction of staff development, supporting decision-making within the project, using data as a learning tool, involving senior staff in meetings with other organisations, and generally encouraging their self-confidence and personal growth.

New challenges

When the VSO placement ended in 1993, and while the future of ARC and its health project was still uncertain, we submitted a paper putting the case for the continuation of the health project, already under discussion by the Vienna Board (the Management Committee of ARC). The Board decided to close down ARC, but with the support of the Austrian Chancellery determined that the health project should continue. The principal donor, a d c Austria, which worked closely with the Board, re-engaged MMP, this time as Development Adviser. The remit was to undertake all administrative work required for the transformation of the ARC health project into a new free-standing Pakistani-registered NGO, including finding new donors to replace a d c Austria as it phased out its financial support.

Chapter 3 of the thesis details this work which was done from 1994-1998, partly in the UK, where information is more speedily accessed, and partly in Pakistan, to help build contacts

with agencies considered likely to be useful. We commuted 3-4 times a year. JSP worked as a volunteer, helping with drafts and meetings, as spare driver and male escort to MMP, in accordance with local protocol, but he did not go out to Pakistan for every trip.

On my last visit as Development Adviser in June 1998, I formed the opinion that the new NGO had acquired enough practical support from a new set of donors—and sufficient self-confidence—to be able to go it alone without further help from either of us, and that it was time for us to withdraw. However, our seven years with the health project had encouraged a view that its development was worth exploring in some depth. Hence this thesis.

Annex 2

List of interviewees

Austria, The Netherlands, Switzerland and UK

Gert Kellermann	MD, a d c Austria
Dr. Max Klimburg	former member of the Vienna Board of ARC
Prof. Christian Reder	" " " " " "
Mag. Wolf Zacherl	" " " " " "
Dr. Gebhardt Breusss	former consultant to ARC/PHC
Dr. Reinhardt Dörflinger	" " " "
Dr A.R. Zamani	former Medical Co-ordinator and Director ARC
Ms. Margaret Usher	former PHC Adviser, Save the Children
Mark Arnold	former Depute Director ARC
Jon Bennett	former Director, ACBAR
Ms.Sally Gray	former Finance Director ARC
Dr. John Seaman	Senior Medical Officer, Save the Children

Pakistan**Individuals**

Prof. Shaheen Sardar Ali	Health Minister, Government of NWFP
Commissioner for Afghan Refugees, NWFP	
Project Director (Health)	Afghan Refugee Health Programme (ARHP)
Dr. Mohammed Iqbal	Depute Project Director (Health) ARHP (deceased 2001)
Dr. Naveeda Rehman	Programme Officer (Health) UNHCR
Col. Altaf ur Rahman Khan	Medical Co-ordinator ARHP
Senior Lady Doctor	PHC Co-ordinator, ARHP
Senior Medical Officer	Trust for Voluntary Organisations (TVO)
Ms. Rukhsana Rashid	Manager, Gender and Development, CIDA
Dr. Shabina Raza	External Evaluator, FPHC, 2000
Two senior staff	UNHCR Office, Peshawar
Two senior staff	The Asia Foundation
Two EDOs (Health)	NWFP Health Department Charsadda and Swabi Districts
Depute EDO (Health)	" " " Mardan District
Dr. Iftikhar Ali	Health Net International, formerly ARC/PHC/FPHC
Director	Pak Community Development Project (Pak-CDP)
Dr. Emel Khan	Director FPHC
Dr. Wagma Reshteen	Female Co-ordinator FPHC
Said Zaman	Administrator FPHC
Sameullah Khan	Master Trainer FPHC

Groups

Staff groups at 3 GOP BHUs	Mardan, Swabi, Charsadda Districts
Male patients	"
Female patients	" "

It was not possible to interview a male patient group at the Mardan GOP BHU: it was being used as a polling station when I visited–Referendum Day. I paid visits to two Charsadda District BHUs in 1998 and 2001 but did not interview patients; at one of these no patients were present.

Staff group	BHU of Afghan Refugee Health Programme
Male patients	" " " " "
Female patients	" " " " "
Senior staff	FPHC
Senior female staff	"
Four male team leaders (doctors)	"
Three veteran male staff	"
Staff groups	Baghicha, Gandaf and Wardaga FPHC Health
Centres	
Male patients	Gandaf Health Centre (refugees)
Female patients	" " " "
Male patients	Baghicha " " "
Female patients	" " " "
Male patients	" " " (non-refugees)
Female patients	" " " "
Female patients	Wardaga MCH (non-refugee women)

Annex 3

Interview prompts for FPHC Senior Staff

1. **Intro: explain my activity:** case study restricted to 1980-2000; try to compare with UNHCR, maybe GOP too; limitation of expectations for FPHC in short term, but useful for others in the field and for future researchers. **Recording and permission; what you really think;** special attention to **Reproductive Health, therefore female staff group too;** perhaps a second go for this group.
2. What are the aims of FPHC (as in Statutes)? How do you think these differ from those of UNHCR? and from GOP?
3. What were the **aims in 2000? Did activities match** the aims? Any changes in direction or additions from original aims or 2000 aims?
4. What **factors have influenced changes in the organisation's development** since 1980? Are there changes in UNHCR's service/policies? Why?
5. What do you understand by "**PHC**"? **Does FPHC measure up** to this? Any gaps?
6. **Participation;** how do people participate? Expression of needs: construction; volunteers; health committees; CBOs—who, how elected: planning, monitoring, evaluation; how can people make their views known; who makes the decisions; women's opportunities'/effect of gender training; "*people are more open*"—why, when and how? Elders, *jirga*, Project Council; village, volunteer reps? Board of Governors?
7. **Collaboration:** who or what does FPHC collaborate with now? form, extent, institutionalised? who made the approaches? CBOs, other NGOs, private sector, GOP, foreign NGOs, FHP etc.? Successful, unsuccessful? Why? Education, water? PH Academy? Hakims, local practices? Hospital referral/follow-up?
8. **Equity:** who in camps/villages does not use FPHC? Why—rich, poor—status/income? What about "guests", nomads, any monitoring? Any appeals from more remote villages? Any ideas about servicing these?
9. **Payment:** what arguments were used for intro? What is fee now? What are the things paid for? Does this deter anyone? What about people with chronic conditions? How do staff identify the poorest—any monitoring of this? What do staff pay for? When did handouts stop? How much was UNHCR/ARC? whose decisions? Do doctors do home visits?
10. What do you see as **strengths and weaknesses of FPHC?** What motivates you? What sort of improvements—additions, deletions could there be?
11. Anything you want to tell me that I've left out—or ask me about?

Thank you very much.

Interview Prompts for Female Senior Staff at FPHC

1. **Intro, explaining it's about a case study of this project 1980-2000.** I want to look in particular at **Repro Health**, but some more general questions first, and I would like **responses from each** of you. Please tell me **what you really think**, not just nice things I might like to hear.
2. Please tell me how long you have worked for FPHC and where you worked before. What **differences do you see between there and FPHC?**
3. **What do you understand by 'phc'?** Does FPHC measure up to that? Are there any things that you think are "phc" but that FPHC doesn't do? How to tackle this?
4. **Participation in FPHC. What are the ways in which women participate?** Exp.of need/views; volunteers; H/Committees; CBOs—who, how often; planning, monitoring, evaluation; breast-feeding groups—in camps too? payment—pregnancy tests; decision-making. **Any notice taken of views of female staff?** Status? PRA—used in Wardaga—anywhere else? How did it help?
5. **Collaboration**—what do you understand by that? Do women think there are ways they could collaborate e.g. with other women's groups or in more remote villages, or putting pressure on GOP Depts.? **What about the LHWorkers (Bhutto)?**
6. **Equity**—Are there **women who don't use FPHC services—in the camps, in the villages?** why not? Could that be improved? Is payment a factor? Do you reach the poorest women? Female-headed households in camps and villages? unaccompanied children? husbands' decisions? **What difference has gender training made? staff only?**
7. About **Repro Health**—read list—are these all part of Repro Health? (STDs, gender-based violence, as well, but no work with patients started on these yet). Coverage in camps v.g. for years—what about villages now? What % births covered in villages? and attendance at <2 clinic? Are follow-ups/defaulters recorded? what is the % of defaulters? Hospital referrals—still Afghan Obst/gynae in Peshawar? Iron deficiency—any change in policy re this or other MCH practice? Health status of guests/nomads/incomers e.g. in Gandaf?
8. **Family Planning—why not much in ARZ's time?** methods; use of sterilisation and termination? Who decides which method is to be used? payment? general attitudes, camps, villages, men, women different age groups; who talks to men about use of condoms? any effect? What might improve uptake?
9. **Training**—TBAs—where? what is difference between TBAs and FHWs? Supervision—line of command—how confident are you re correct recording? Inducements?
10. On the whole, how do you think the service of UNHCR or GOP in R/health/FP compares with FPHC?
11. Anything else you want to ask or you think I've left out? Thank you very much

Interview prompts for Team Leaders at FPHC (male doctors)

1. **Explain my activity:** case study over 20 years; restrictions –so concentrate on selected years; focus on comparison w. UNHCR services, maybe w. GOP too; special attention to Repro health. **Want to know what you really think, so senior female staff group too.** Would like **each of you to respond** to each question. Want to tape-record discussion, and hope you will agree to this. **Confidential—no names recorded**, just job titles. Verbal or written?
2. Please tell me **how long you have been with FPHC and where you worked before.** What is different about FPHC?
3. What do you think are the **aims of FPHC? How do you think these differ** from UNHCR and GOP?
4. Did FPHC's activities in 2000 match these aims? has there been any change in direction from original aims? or additions?
5. **What factors or people have influenced changes** over the years? "people are more open". When did camp people become more accepting of procedures?
6. **What do you understand by "phc"?** Does FPHC measure up to this?
7. **Participation :** how do people participate? Expression of need, construction, VHWS, H/ctees , CBOs; planning, monitoring, evaluation, how can people make their views known—do they make suggestions/criticism to you as T/Ls; how do you make suggestions or criticisms—**does senior management take any notice/action?** Project Council?
8. **Collaboration :** who does FPHC collaborate with? are there any problems with this?could there be other kinds of collaboration? What about hospital referral and follow-up? can anything be done about this?
9. **Equity :** who in camps/villages does not use FPHC? why? where do "guests" come from? are they recorded? what about remote areas—could FPHC do more for them? **Payment—does that put anyone off? What effect has gender training had on your practice?**
10. **Men's use of FPHC**—defaulters? attitudes to MCH/F/P—condoms? How willing are men to pay/let women come/pay for women's treatment?
11. What do you see as the **strengths and weaknesses of FPHC?**
12. Anything else? Thank you very much.

Interview prompts for Staff Groups (mixed) at FPHC Health Centres

1. **Intro: Many of you have seen me before;** John and I came here in 1991—as Administrator and he was Medical Adviser. Then I came back as Adviser and John helped too. Now I want to write a case study of the project and how it has changed over 20 years, so I need a lot of new information and **I need your help. It will all be confidential—I don't need your names. Do you agree to be interviewed?** Is it OK to agree verbally or do you want to sign something to say you are willing?
2. I would like **each of you to answer** my questions if possible. First I would like to know **your job titles, and how long you have worked for ARC/PHC/FPHC**; I would also like to know **if you have worked for any other organisation**. In what ways is FPHC different? or for long servers—what changes have you seen? what are your views about these?
3. Please tell me **what you understand by “primary health care”**.
4. **Do you think FPHC does this?** Is there anything missing? Why?
5. **Participation:** tell me how you think people participate; exp. of need, construction, volunteers, H/cttees, CBOs—who, how elected; planning, monitoring, evaluation; how can you as members of staff make your views known to management? **what happens if you do? Annual Meeting?** who makes the decisions? Project Council? how do you think the people in camps/villages make their views known? what happens if they do?
6. **Collaboration :** you know about other NGOs and other agencies –tell me who these are; LHWorkers, GOP BHUs. Are there **other ways of collaborating** e.g. education, w/sanitation, training of NGOs. Has any other agency approached any of you personally about some kind of collaboration?
7. **Equity :** Are there **people in the camps/villages who don't use FPHC**—if not, why not (private Drs. at w/es?) What might encourage them to do so? What about “guests” and nomads? Is any record kept of their contact/treatment—do they come back again—any regularity? What about remote villages?
8. **Payment—does this deter anyone?** if he/she has to come back to OPD for the same episode of illness, do they have to pay again? Lists of those who don't pay—any abuse? who decides who goes on the list—can people come off again? How many of these people are there? Widows?
9. Have any of you **worked for other organisations?** where, and what is different?
10. What are the **strengths and weaknesses of FPHC?** What do you think would make your **work more effective?** anything else you think FPHC should do? Why are records important?
11. At Baghicha—there are Afghans and Pakistanis both using this HC - is there anything special about that?
12. **Any thing else** you can tell me or want to ask? **Thank you very much.**

Interview prompts for Registered Patients at FPHC Health Centres

1. Explain use of **interpreters**. Some of you may have seen me before. John and I came here in 1991-93 as Admin; he was Medical Adviser. Then I came back to help with changes and John helped too. I visited last in 1998. Now I want to write **a case study of this project** and how it has over 20 years from 1980-2000. So I need a lot of new information and I need your help. It will all be confidential—**I don't need to know anyone's name, but I would like to tape-record what is said. Do you agree to be interviewed?** and is it OK to agree verbally/or sign a paper to say that you have agreed?
2. I know that you want to be courteous and say nice things to a guest, but **I want to know what you really think. I would like each of you to answer the questions.** First of all, please tell me how **long you have been married and how many children** you have. How long you have been in this camp? What was it like when you came? What are the changes in the camp itself?
3. Was it **always ARC/PHC** which provided health care? So what changes have you seen over these years? What do you think about these changes? no handouts now? **Why** do you think these changes have taken place?
4. What are **the services that you or your families** can get at FPHC at present? What do you think about the **quality** of these services? are some more important/better than others?
5. **You have to pay for** some of these services now? do you think FPHC should charge for these? are the services worth paying for? How do they compare with services you have experienced elsewhere? or—**do you know people in other camps or not in camps at all—what do they think about the services they use?** **At Wardaga**—tell me about the medicine bank. Some people don't pay—what do you think about that?
6. Do you know if there are **people in the camp/village who don't use FPHC?** If not, why not? What do they do for health care? How could they be encouraged to come to FPHC? What do people do at w/es? Are there any families with no man? do they get help from FPHC?
7. **Is there a Health Committee** in this camp/village? How are members chosen? Male/female? Can you speak to it/make suggestions/complaints? Does anything happen? what is the Committee supposed to do? **Do people want** to have more involvement? **do women want to be more involved?**
8. **Do all women use the MCH?** if not, why not? **Family spacing?** when do women ask for it? choice of method—who decides which it will be? are there women who don't use it? why not? Are the men willing to use condoms themselves? Do you think women can make their views known?
9. Are there **other services** FPHC could provide? e.g. education?
10. **Going home**—what do people say about this now? and the young people?
11. Is there **anything else** that you want to tell me or to talk about? **Thank you etc.**

Interview prompts for Executive District Officers (Health)—formerly DHOs

1. **Intro: explain who I am, connection w. FPHC since 1991, mention JSP.** Explain change of role : case study 1980-2000, FPHC now provides a service to villagers as well as to refugees. Special attention to Repro. Health. Intend to compare FPHC's services with those of UNHCR, and would like to include GOP field services!—not secondary ones. **Permission granted by Health Minister.** Consent please to interviewing and tape-recording—written?
2. **Was there any collaboration before FPHC became an independent Pakistan NGO?** Some collaboration with FPHC : in what ways? what indicators were used? were these formally agreed? **What sort of monitoring or evaluation is done re this work?** record of this? Some experimental collaboration? e.g. possible involvement of BHU in Ismaila? what is expected from that? how will this be monitored and evaluated? **what about the NHWs—any connection w. local GOP systems?**
3. Apart from medical care, **might any thing else contribute to improving health of the population in the area?** e.g. water/sanitation, education? How could something be done about that?
4. FPHC says it provides “ phc” . **What do you understand by that ?** Is that a justified claim?
5. What do you see as the aims of the GOP local H/system? does this reach everybody—if not why not? what are the various programmes and reporting systems? **can I have copies of these?**
6. **How many BHUs does a DHO have responsibility for?** so how often do you see each one? do they know you are coming? Do you have responsibility for hospitals as well? How much **freedom/discretion** do you have in what you want to do in your geographical area?
7. **Are local people involved with BHUs in any way other than patients?** e.g.volunteers,health committees,relationship between BHUs/ District/CBOs?
8. Specifically, **how can MCH and F/Planning use be increased in NWFP?**
9. **What things would help** to make the service better/ make your work more effective?
10. **I would like to visit at least one BHU and talk to staff and patients.** If I have your permission, no special arrangements. Copies of forms etc.

Thank you very much.

Interview prompts for BHU Staff Groups (GOP/Refugee Health Programme)

1. **Intro :** You will not have seen me before, but I have been coming to NWFP since 1991; I was last here about a year ago. My husband and I have always worked with FPHC, which works in 3 camps in Mardan and Swabi Districts. Now I want to learn more about the health care provided by GOP/ARHP BHUs. So I need your help. Do you agree to be interviewed? Do you want to sign a paper or is verbal agreement OK? It will all be confidential, so I don't want to know your names But I would like each of you to reply to my questions. Is it OK if I record what you say?
2. First I want to know **job titles, and how long you have worked here. Is this the whole team? Anyone missing? why?** Where do problems go? Line of reporting /responsibility? Supervisory visits? Annual report/staff meeting?
3. What are the **services/programmes that people can get here? Any use by refugees in the neighbourhood?** Why? When was each of these programmes introduced? What are the aims of the service?
4. How organised? Opening hours? At night, weekends? **attendance, men, women, children?** Recorded? **Supplies/transport? Any activity in schools?** Any NGOs active—work with them at all? Staff can make views known to management? Any notice/action taken?
5. Target population; which villages? static or not? % M/F/chn? Recorded? Any changes? **Where do staff live/how get here?**
6. **Do any villagers use other health services**—private, hakims, other BHUs (inc UNHCR)? More people come from villages nearer to the BHU? Rich people? "Guests", nomads, remote villages?
7. **Payment**—do people have to pay for any service here? How collected? Deterrence/exemptions? Help if need to use another service?
8. **Hospital referrals**—where to? any feedback? Who pays? Any help?
9. **Volunteer health workers**—male, female? selection, training,etc?
10. **Health committee?** Any other groups—women's? People make suggestions/complaints? What happens if they do? Construction etc.? Annual meeting/evaluation? **MPA helpful?**
11. **Repro. Health, esp F/P :** what sort of uptake? Methods, supplies? When did it start? Training? Attitudes—men, women?
12. **Did you work somewhere else before this?** How is this different? What do you think about these differences?
13. Any idea about **how this service compares [with what refugees get]?** Or with any other service?
14. Please tell me **what you understand by "primary health care"?** Is that what this BHU does?

15. **What might help you to do your work better?** Or anything else you think this service should be doing?
16. Anything else you want to ask or to tell me? Thank you very much.

To get : Data recording instruments ; who gets them? Any responses?

Selected years data

Drugs list

Staff lists for selected years

Content of training

Interview prompts for Patient Groups:

GOP—Male/Female
ARHP—Male/Female

1. Intro as usual: **explain use of interpreters**; permission to interview and record. I don't want to know names, but please each of you answer the questions as far as possible. I am a guest, but please talk "*speen*".
2. **[How long have you been in the camp], how long married and how many children?**
3. **What are the services that you and your families** can get at the BHU? What do you think about the quality of these? Are some of these services more important than others? Are the services different from **what was available in Afghanistan—or in other camps?** [or at other GOP BHUs]
4. **Has people's health improved** since you came into the camp? Why is this? Ask esp. re children. **[Have you noticed any improvement in people's health in the last 5- 10 years?]**
5. Do you have to **pay for these services**? Is that OK? Exemptions? Do people in this camp use other services? Why, what kind, where? Costs?
6. **Are there people who don't use the BHU at all?** Why not? Should they/how could they be encouraged to come to the BHU? Or if you know Afghans not in camps at all—what do they do? **Do some non-refugees use this BHU?** Why? What do you think about that?
7. Hours of availability; **what about outside hours and w/es?** Transport/costs for hospital? Medicines/supplies? Staff attendance/attitudes?
8. **Involvement** : construction, committees, groups, women's groups; meetings with staff—elders, *jirga*, others?
9. **Any NGOs active** [in this camp?] BHU involvement in schools?
10. **Can [camp] people make comments/suggestions?** How? Any action?
11. **Do your wives come to MCH clinics?** Do you know any men who do not allow this? Any home visiting?
12. **What about F/Spacing?** Do you know what methods are available? How do you learn about them? **What is a good family size?** (for women—tell me about the lady doctor/labour room).
13. **What are people saying about going back to Afghanistan?**
14. Is there anything else you think this service should be doing?
15. Is there anything else you think I should know or that you want to ask? Thank you very much.

Interview prompts for Donor Organisations (CIDA, TAF, TVO)

1. **Intro re self, change of role; purpose.** Talking to range of people. Interest in years 1980-2000, at five-year intervals. Comparison with UNHCR, and GOP if possible. Hope I can fit in some donors too. Consent, confidentiality, taping or notes.
2. **How did (donor) you learn about FPHC?** Or about any NGO? How easy/difficult is it for you to get this kind of information?
3. **What indicators do you use to decide that an NGO is worthy of support?** And FPHC in particular?
4. **What do you understand by “phc”?** Do you think FPHC is justified in saying that it does this? Do you see anything missing?
5. **Do you have any opinion on the kind or standard of care provided in the field by UNHCR and/or GOP?** or any other NGO?
6. **FPHC talks a lot about participation.** How do you think they implement it? Could they encourage participation in any other ways? Or are there other ways of participating?
7. **How about co-operation or collaboration?** What kinds do you think FPHC practises? What else might improve the standard of health care to their target population—or the health of the poor generally?
8. **Do you think that there are people that FPHC doesn’t reach?** Why not? Could FPHC do more about this? **Could you as a donor** help with problems related to this?
9. **Why did you choose to support it in the various ways that you did/do?** Is this a matter of guidelines/policies/fashions from GOCanada? How “local” is discretion?
10. **What factors or people do you think have been influential in the changes in FPHC’s remit and practice**—in the years you have had contact or even before that? (depending on what the particular donor knows).
11. What do you think are the **strengths and weaknesses of FPHC?**
12. **Anything else? Thank you very much.**

Annex 4

Five research questions: five charts

Research Questions	Data Sources and Methods	Justification	Practicalities e.g. resources, access, skills	Ethical Issues
1. How far did/do UNHCR/FPIC meet WHO's listed components of primary health care?	<p>Aims, activities, structures, statistics etc of UNHCR and FPIC as in Annual Reports and other formal documents of both orgs. for 5 selected years 1980, 1985, 1990, 1995, 2000.</p> <p>Interviews with senior staff and field staff of both orgs. (Individual and/or group) to be tape-recorded.</p> <p>Focus groups with regd. patients in UNHCR camps/FPIC camps and at most recent FPIC Health Centre (no refs) also with non-refs; also with volunteer health workers.</p> <p>Interview with Commissioner for Afghan Refugees (CAR)</p> <p>Interviews with senior UNHCR staff in Islamabad ? health specialist ? any relevant central records</p> <p>Participant observation of FPIC Governors meeting; also of Project Council meeting (staff group)</p> <p>Interview with Dr. ARZ</p> <p>Interview with N.J., first Director of ARC/FPIC</p> <p>Group interview with former members of Vienna Board of ARC</p>	<p>Should enable composition of parallel position statements at specific dates over period to be researched</p> <p>Should enable "fleshing out" of written records, assessment of individuals/organisational understanding of components of primary health care at different levels; do they recognise gaps in provision?</p> <p>Should enable expression of their opinions positive/negative of provision; their understanding of its aims; do they see gaps—what would they like; do they use other health services, if so why and when</p> <p>Should obtain overview of h/care for refugees and opinion of FPIC as provider. What is his understanding of phc? Can he say why/when FPIC was appointed UNHCR's agent in 3 camps? are there records of this?</p> <p>Some HQ staff may have info re UNHCR policies and discretion re decision-making; ? what is UNHCR understanding/implementation of phc</p> <p>Should enable assessment of both groups' understanding of phc—gaps, intentions, problems, decision-making</p> <p>Should provide info on how he obtained knowledge re phc to enable him to become creator of FPIC in 80s. What was motivation, expectations, plans?</p> <p>Should provide info on development of health focus; relationship with UNHCR and CAR</p> <p>Information obtained on foundation of organisation in 1980 and early health focus</p>	<p>All FPIC A/reports etc. In my possession; UNHCR to be approached locally re local reports. Also library research in Edinburgh/Oxford (RSC). All reports of FPIC (and UNHCR) are in English. Select MCH/Family Planning stats for analysis</p> <p>Staff changes over 20 years may limit access to possible significant contributors, but there is a good relationship between UNHCR and FPIC at this level. Telephone/ email interviewing may be required. Staff changes likely to be more of a problem with UNHCR than FPIC. Field staff interviews will need an interpreter—English is variable.</p> <p>Composition requires careful management: separate M/F groups; sampling to obtain wide spread of ages/ length of stay in camps (e.g. since 1980, from other camps, recent arrivals, older people). Interpreter essential. These groups the most time-consuming but v important.</p> <p>Depends on availability and how long he has been in post. May be able to provide written records. Speaks English.</p> <p>Above all in Peshawar/ Mardan neighbourhoods, NWFP. FPIC will provide office space, computer, car and driver. Interviewing skills required. Battery tape-recorder/transcriber from EU Soc Dept</p> <p>Travel/ accommodation easily arranged. Willingness of UNHCR staff to share policy info may be problematical. Staff turnover also a possible problem.</p> <p>Depends on whether meetings are scheduled during fieldwork visit. Some interpretation needed. Tape-recording probably agreeable.</p> <p>Now working in Hayward, CA. Tel/ email interviewing only, unless coincidentally in Pakistan, or visiting Europe</p> <p>Now based in The Hague; contact established; international consultant; personal interview not impossible but he is v mobile</p> <p>Done in March 2000 during visit to Vienna</p>	<p>Reference to individuals by job title only; obtain written consent or by email if necessary</p> <p>As above</p> <p>Consent for tape-recording</p> <p>Identification not needed but gender issues suggest women</p> <p>need husbands' permission; consent to tape-recording problematic, ? written notes. Clear explanation essential—turnout/suspicion endemic.</p> <p>Consent to interview needed, identification by job title</p> <p>Identification by job title</p> <p>Identification not necessary, or at most by job title.</p> <p>Serious security problems; identify difficult to protect.</p> <p>Possibly some security problem, but not so serious as above</p> <p>Confidentiality issue not clarified</p>

Research Questions	Data Sources and Methods	Justification	Practicalities e.g. resources, access, skills	Ethical Issues
2. How far did/does each organisation UNHCR and FPIC implement the "3 pillars" of primary health care?	Examination of written material as at 1. above	Should produce evidence of understanding of 3 pillars; e.g. inclusion in aims and objectives, attempts at activation in practice	As at 1. above	None likely
	Interviews with staff at both orgs. at different levels as above	Should clarify whether the concepts are understood (even if the words are not in use); how has understanding and practice changed (if at all) over the years? Are decisions/plans made taking the 3 pillars into account? Should provide info re relationship between 3 pillars and e.g. cultural perceptions of leadership.	Similar to 1. above	As at 1. above
	Focus groups with regd patients etc. as at 1. above	Should uncover how far they are involved in planning, decision-making, practical work e.g. construction, monitoring, evaluation. Do they want more or less involvement? Do they see think the organisation can do other things? Do they think there is unfairness or nepotism/ how far is this acceptable? Should produce info on their view of volunteer h/workers	Time consuming but very important as at 1. above	As at 1. above
	Interviews with senior UNHCR staff in Islamabad as above, also with CAR in Peshawar	Should provide clarification and info on same topics as for senior/land field staff in local settings. How is UNHCR approaching phc in refugee camps in Pakistan and other refugee situations/? How flexible can UNHCR be?	As at 1. above	As at 1. above
	Interviews with Dr. ARZ, NJ	Should clarify motivation, explanation of slogan "helping Afghans to help themselves", delegation, sharing responsibility, decision-making; their opinions on how cultural practices affected h/care/org. development—advantages/disadvantages. When/what was point of divergence from UNHCR? Do they have views/experience on collaboration or equity?	Constraints on contact as at 1. above	Securely a problem esp. for Dr. ARZ
	Focus groups with volunteer h/workers in both orgs.	Should clarify how they see their role—extent of participation, status/relationship to field/ senior staff?	Not known at present whether UNHCR uses volunteers; if not, still important to meet with FPIC volunteers	Identity need not be known; gender issues re husbands' consent/ recording relevant.

Research Questions	Data Sources and Methods	Justification	Practicalities e.g. resources, access, skills	Ethical Issues
3. What alternatives exist (ed) for refugees and local people?	<p>Search of literature on Govt of Pakistan (GOP) health care plans and services (Jeffery et al); UNHCR reports</p> <p>Annual Reports of Social Policy Development Centre, Karachi</p> <p>Human Development Reports on Pakistan and Afghanistan</p> <p>Interview with senior member of FPIC staff who has also worked in GOP sector</p> <p>Interview with private practitioner who used to work with FPIC</p> <p>Focus groups with regd. patients as above</p> <p>Also with 1 or more GOP BIU staff if possible</p> <p>Interview with Dr. ARZ</p> <p>interview with NJJ</p> <p>Interview with Provincial Health Secretary, NWFP</p> <p>Interviews with DHOs for Mardan, Swabi and Charsadda Districts</p>	<p>These should set out what is officially available to the rural population; UNHCR may have info on alternative refugee provision, including refugees not in camps</p> <p>These provide a critique of GOP services and health problems</p> <p>Statistics for Pakistan re public health provision (e.g. safe water) and specific needs like mother/child health should provide evidence of service trends/effectiveness</p> <p>Professional experience of both systems in rural area</p> <p>Professional experience of private and NGO systems</p> <p>Should provide evidence of use of non-UNHCR and non-FPIC systems, including ayurvedic medicine</p> <p>Should provide info health care in rural Afghanistan before refugee exodus; personal observations re this and his approach to h/care</p> <p>Similar to interview with ARZ</p> <p>Should provide GOP view on h/care provision for locals and for refugees</p> <p>Should inform on what they see as strengths/weaknesses of GOP system; also opinions on private practice and NGOs—on FPIC in particular; also knowledge of phc and the 3 pillars</p>	<p>Some in my possession; more research in EU Library including Erskine; also more research in Refugee Studies Centre, Oxford for info on refugee h/care.</p> <p>EU Library</p> <p>EU Library</p> <p>Now working at FPIC</p> <p>Believed to be in Mardan area, reasonably accessible, willingness to be interviewed unknown</p> <p>Composition etc. as 1. above</p> <p>Tel or email only possible as at 1. above</p> <p>As at 1. above</p> <p>Depends not only on day-to-day availability but on how stable GOP is—identity/situation could change anytime</p> <p>Reasonably accessible, but perhaps likely to be rather defensive</p>	<p>Public Information</p> <p>Identification by job title</p> <p>Reason for leaving FPIC unknown</p> <p>Gender issues etc as before; both sexes may feel threatened by questions re use of other systems</p> <p>GOP staff also, if they venture to be critical</p> <p>Security problem as above</p> <p>As at 1. above</p> <p>The present post-holder (female) is sympathetic to FPIC</p> <p>Identification by job title; but local practice does not favour privacy in office situations. Gender issue may mean that I need an escort which may affect confidentiality</p>

Research Questions	Data Sources and Methods	Justification	Practicalities e.g. resources, access, skills	Ethical Issues
4. What impact has each organisation (UJHICR, FPIC, GOP) had on the health of the community (1980-2000)?	<p>Reproductive Health Programme within each organisation for 5 selected years as at Q.1</p> <p>A/R reports etc. of 3 orgs. for aims and objectives as documented; Evaluation Reports</p> <p>Interviews with senior staff in all 3 orgs.; esp. senior female staff of FPIC</p> <p>Focus groups with field staff and regd patients (reps and local people as before); vols. also</p> <p>Dr. ARZ/HJ</p> <p>Dr. IA (has worked in GOP health as well as at FPIC)</p> <p>Dr. R (now works in private sector, has worked at FPIC)</p> <p>Provincial Health Secretary</p>	<p>Time will not allow examination of all programmes in detail, but Repro. Health is a large programme with several components, applicable to approx. 75% of total target population (i.e. women and children)</p> <p>Admission/identification of successes/ shortfalls/ omissions/failures in practice</p> <p>Should provide info on reasons for level of uptake among refs/local people; roles of junior staff/vols.; use of inducements; charges to patients; termination used?</p> <p>Should clarify attitudes re MCH care etc. esp. F/planning; charges for contraceptives</p> <p>Should provide info on how refs. were persuaded to accept MCH services, introduction of training of TBAs; use of recording/statistics; why not much F/planning during ARZ's time? What did he regard as success/failure?</p> <p>Should provide info on use/availability of MCH Inc. F/Planning in GOP sector; patients' attitudes; personal comparisons with FPIC</p> <p>Info on use/availability similarly re private sector</p> <p>Should clarify GOP views (and her own) on availability/ impact of F/planning and MCH in NWFP; what are the</p>	<p>At FPIC, stats/graphs/charts available for most years for a/natal care) p/natal care) Repr. Health deliveries) under 2 clinic) nutrition) f/planning) EPI)</p> <p>Stats etc. available from UJHICR and GOP may not cover same components Familiarity with Excel useful?</p> <p>Questions should be addressed to male groups also</p> <p>If only tel. or email interviewing possible, responses may be limited</p> <p>Available</p> <p>Availability uncertain</p> <p>Worth contacting even if no longer in post?</p>	<p>Excludes any data on adult male health except re f/planning</p> <p>Reliability of stats. etc in all 3 orgs.; If not, why not?</p>

Research Questions	Data Sources and Methods	Justification	Practicalities e.g. resources, access, skills	Ethical Issues
5. What factors have influenced changes in FPIC's remit and practice?	AR/Reports as before of ARC, FPIC and UNHCR AR/Reports of Pak CDP Members of Vienna Board External Evaluation Reports of ARC (1994) and FPIC (1998) and other minor interim evaluation reports Interviews and focus groups as above Interviews with UNHCR senior staff Interviews with Dr. ARZ and HJ Interviews with selected donors (e.g. GOI/Secretary, GOP District staff, TVO, British Council)	Should identify points of divergence in policies and practice between UNHCR and FPIC Project of ARC which became an independent NGO in early 1990s (precedent for FPIC) original policy and decision-makers... ultimately closed ARC, agreed that project should continue 1994 makes recommendations for development of health project based on comprehensive survey of all ARC activities (including statistics); others make relevant comments; 1998 deals with FPIC only should provide personal opinions and accounts of why FPIC has changed -- In particular those of local people Should provide info re why UNHCR recently modified support to FPIC Should elicit opinions on their own and others' roles in change and development What indicators did they use in decision to support FPIC financially or otherwise; or why withdrawn	Many in my possession as above; others to be obtained in Peshawar/Islamabad Office is in Peshawar; should be easily obtained. Some info already (Vienna visit March 2000)--- can be expanded via email All in my possession Groups should include refugees and local people who began to attend project spontaneously; memories may be faulty Fact and diplomacy may not be enough As previously stated Check out who are current donors and who may have withdrawn	None expected None expected There may be Austrian political (and personal) considerations which may make info-sharing difficult May need authors' permission to quote from reports As with all these groups, important not to raise false expectations of immediate or long-term material benefit to individuals or to the orgs. Political considerations within UNHCR may compromise sharing As previously Not likely to be problematic

Annex 5

FPHC: after year 2000

This annex provides a brief outline of how FPHC has tried to carry its work forward in the since the end of the 20-year period of the case study. It is not a detailed comprehensive account, but draws on the Annual Reports (AR) of 2001, 2002 and 2003. It mentions some problems experienced during that time and recorded in the Reports.

With the same leaders in post, FPHC continues to function in 2004. In 2002 it claimed a target population of 150,000 registered patients, including the original refugee group. In 2003, although there was some repatriation of the large refugee population, the majority stayed in Pakistan:

“especially the population in the three camps served by FPHC is stable and there is no significant movement” (AR 2003:9).

Continuing programmes:

- Reproductive health (formerly MCH/family planning)
- Preventive (EPI, control of malaria, TB and diarrhoeal diseases)
- Rehabilitative (nutrition, physiotherapy)
- Diagnostic/curative (OPD, laboratory and pharmaceutical service, dental care)
- Health promotive (home visiting, school health, health education)
- Education Centres (formerly play parks and girls’ classes)

Apart from omitting installation of safe water and sanitation, the components of PHC (including provision of essential drugs) are still integral to these programmes. In the three camps, sanitation maintenance has remained a responsibility of the residents; staff inspect and give assistance e.g. by arranging chlorination of water sources, bulk buying of latrine slabs or ventilation pipes. Villagers can receive advice from staff.

The Annual Report 2002 (p 11) states that about 270 girls 8-16 years attend classes in the Education Centres (formerly girls’ classes/Vocational Centres). In addition, at Wardaga village a formal school was set up—6th and 7th classes for girls—because the GOP “middle school” was so far away that travel to it was inconvenient and expensive. The local CBO and its women’s section was instrumental in this initiative. Students pay Rs 5-10 per month; all these Education Centres have waiting lists (AR 2002: 65-67).

Changes in clinical programmes:

Reproductive health

continued to raise awareness on MCH and nutrition via discussion groups in the community; introduced raising awareness on HIV/AIDS and on adolescent reproductive health (with help from World Population Foundation (WPF) and the local Reproductive Health Alliance); and added control of STDs.

The Annual Reports indicate a rise in the number of women seeking ante-natal care, supervised deliveries and post-natal visits. These improvements refer to villagers; figures for camp women indicate a continuing high level of usage. In 2001, the family planning programme included 1936 women (AR 2001: 23). Couples with problems of infertility are also receiving advice and onward referral.

The 2002 Report states that training in gender sensitisation was extended beyond staff to volunteer health workers, and claims that attitudes of male staff to female staff improved. The Report also claims increased male interest in family planning, previously regarded as a female concern. Female staff are said to have become more interested in lab. and pharmaceutical work, hitherto regarded as men's work (p 19).

Chapter 10 of the case study referred to recent research by Hafeez et al. (2004) criticising inadequate integrated care for obstetric and neonatal cases from both refugees and non-refugees. FPHC had been concerned about this for some time and in 2002 established its Reproductive Health/Essential Obstetric Centre in Mardan Town "*at a site accessible for all refugees living in Mardan, Swabi and Charsadda Districts*" (AR 2002: 5). This Centre is staffed by two lady doctors, two staff nurses, and includes a laboratory and transport back-up. It provides 24/7 care and accepts women not only from the three FPHC camps but also from BHUs run for refugees by other NGOs in these Districts (Kuwait Joint Relief Committee—KJRC, and Union Aid for Afghan Refugees—UAAR); it also accepts refugee women living in local villages. It can undertake forceps deliveries, but complicated cases (not defined in the Report) continue to be referred to GOP hospitals. The Centre is funded by a d c Austria and does not treat village women. AR 2003: 25 explains that because this is a secondary level facility, it is not free, but the Report does not detail charges.

Preventive work

in 2001 added training of some staff in the prevention, detection and treatment of Leishmaniasis. This was a precautionary measure, because some cases had been reported in camps, though not in the FPHC camps at that time. The disease is thought to have been

brought into Pakistan by recent arrivals from Afghanistan, where it is endemic (AR 2001: 27). AR 2003: 49 records an incidence of Leishmaniasis in Gandaf village of 0.27 per 1000.

Diagnostic and curative work

has added to laboratory work since 2002 tests for syphilis, toxo-plasmosis and brucellosis.

Rehabilitative programme

was strengthened in 2001 by periodic visits from Pakistan Red Crescent staff (1 doctor and 2 technicians) to provide specialist opinions and refer individual patients for treatment in Peshawar (AR 2001: 39).

Human Resources Development Unit

The Reports state that many of the changes mentioned above were instigated and implemented by this Unit. The Unit's three broad aims stress community participation:

- *“to build the capacity of FPHC's staff members and volunteers and members of other NGOs/CBOs on primary health care including reproductive health and adolescent reproductive health”*
- *“to bring behavioural change in families especially men and women through support groups methodology on MCH and nutrition”*
- *“to increase awareness in community in order to decrease gender discrimination through sensitisation of FPHC's staff members, volunteers and members of other NGOs/CBOs (AR 2001: 40)”*

Regular in-service and refresher courses for staff and volunteer health workers and training courses for new volunteers continued. The Unit also developed some teaching and research materials such as posters and questionnaires.

External relationships

With other NGOs:

FPHC provided some training to local NGOs/CBOs e.g. in counselling and in running groups, and referred some of these on to a specialist NGO (Strengthening Participatory Organisation—SPO) for training in development, planning and management. FPHC received deputations from two NGOs in Sindh Province interested in FPHC's work-style, and itself sent a staff group to NGOs in Haripur and Abbottabad (SCF and IRC) to observe these NGOs in action. A staff group from FPHC also visited the Health and Nutrition Development Society (HANDS) in Karachi (ARs 2001, 2002).

With GOP:

FPHC strengthened its relationship with GOP by joining the new GOP Committee on HIV/AIDS, continuing to deliver immunisation on GOP's behalf to designated villages outside its own target area, and inviting some GOP LHWs to join the FPHC STD/HIV/AIDS training courses. Contact with GOP's Provincial Health Services Academy became a more formal collaboration: the Academy sent 101 trainees, mostly of managerial level (doctors, LHV's, medical technicians) in batches of 20-21 for 1-2 day orientation courses to FPHC in 2002 (AR 2002: 60).

In 2002, GOP launched a new programme to improve health and education indicators in Pakistan via a "National Commission for Human Development (NCHD)". It chose FPHC as one of four partners in a "PHC Extension Project" in Mardan District (AR 2003: 35). FPHC thus acquired an additional 50,000 target population in two local sub-areas, necessitating recruitment of extra personnel. In 2002 FPHC employed 153 trained and experienced people, including administrative, financial and teaching staff (AR 2002:10). AR 2003: 5 records the overall number of trained and experienced staff as 220; the total number of volunteer health workers was 272.

With other agencies:

FPHC became involved with the Reproductive Health Consortium for Refugees (RHR) and the University of Columbia (both USA) working on a Family Planning Continuation Study using data on Afghan refugees. This culminated in Dr. Emel Khan attending the Global Health Council's annual conference in Washington DC in May 2002, on the invitation of the John Snow International Research and Training Institute. He presented the findings of the study to the conference (AR 2002: 6).

Arising out of the long-established relationship with CIDA, FPHC had discussions with the Canadian Executive Service Organisation (CESO) about possible volunteer support to FPHC. This was intended to improve FPHC's research capacity, and proposed a tripartite arrangement including also the paediatric unit of the Khyber Teaching Hospital in Peshawar. But these plans were overtaken by events.

9/11 and its consequences:

The attack on the Twin Towers in New York on 9th September 2001 had repercussions far beyond the USA. American military activity resulted in more population disruption in Afghanistan. UNHCR/GOP, expecting an influx of one million more refugees, earmarked about a hundred sites for new camps, mostly in the tribal belt adjacent to Afghanistan. FPHC

took part in discussions on health care for the expected arrivals, and prepared to staff two new Health Centres in these areas, or alternatively to expand its existing Health Centres if the refugees entered the Mardan/Swabi Districts. In fact the new wave was much less than expected; only about 20,000 Afghans were accommodated in two new camps. The small residue either joined relatives in old camps or were absorbed into the urban population (AR 2001: 7). There was in the end no need for extra provision by FPHC.

However there were local repercussions for FPHC and other NGOs, especially those believed to have western connections, as recounted in chapter 2. Daily work was temporarily affected, especially outreach activity by female staff, who felt very threatened. In fact there was no damage to material resources, but a high level of anxiety persisted. In these circumstances, the Canadian volunteer couple (both doctors) recruited by CESO were unable to come to Pakistan (apart from a brief preparative trip in early 2001) but they have maintained contact with FPHC. One of their responsibilities when their visit to Pakistan becomes a reality will be to work on a five-year strategy for FPHC. (AR 2003: 79).

New needs:

Although the population of the three camps has remained stable, interest in possible repatriation stimulated responses from FPHC for some families:

- *a birth-planning programme* was introduced for pregnant women intending to return to Afghanistan, the assumption being that skilled hands and hygienic conditions would not be readily available. These women received extra health education and a delivery kit. Women in the family planning programme received supplies for 2-6 months, depending on the method. ORS was also supplied.
- *TB patients* received intensive health education on continuing treatment and received one month's supply of medication.
- *the family record book* (containing the family's up-to-date health and immunisation record) was returned to the family at time of repatriation, and advice was given on available health facilities in Afghanistan.
- *training of extra CHWs* in the camp population began in preparation for post-repatriation circumstances in Afghanistan (reminiscent of ARC policy in the 1980s when early return to Afghanistan was expected). Camp residents asked that some young literate females be trained as LHWs as well. A total of 71 volunteers were trained, male and female (AR 2002: 60).

Charges

The standard charge of Rs 10 per head per visit to a Health Centre continued, and some other charges were introduced at Health Centres serving villagers. Following discussions with local CBOs and *jirgas*, families paid Rs 20 for each new family record book issued. Ismaila villagers demanded dental care, for which they agreed to pay full costs—Rs 20 for an extraction, Rs 50 for a filling. At this Health Centre and at Wardaga, women paid Rs 5 for an ante-natal check-up, and there were charges also for deliveries and family planning (AR 2002: 24).

Problems

Apart from the repercussions of 9/11, the Annual Reports record other problems, some likely to be recurring or chronic:

- The *experimental medicine bank* begun in Wardaga continued to be unsuccessful, partly because this relatively new Health Centre still had to stress prevention. Poverty meant that many people could not afford to pay cash for medicines; they preferred to go to local quacks who “loan” medicines, to be paid for on a 6-monthly basis or when crops are ready for sale.(AR 2001: 8).
- *Shortage of staff* (lady doctors) affected Reproductive Health in two Health Centres for a few months in 2002 (AR 2002: 9).
- *Supplies of contraceptives and vaccines* could be problematical, but FPHC aimed to cope by getting supplies from several sources (GOP Population Welfare Department and Directorate of Reproductive Health Services, as well as Project Director Health of the Afghan Refugee Health Programme).
- *Rapid transfer of staff in GOP Departments* (noted during fieldwork in 2002) affected smooth collaboration between GOP and FPHC. FPHC management considered that both organisations would benefit from institutionalisation of their collaborative relationship (AR 2002: 9, 2003:4).
- *Financial sustainability*: FPHC recognises that this is an ongoing problem for NGOs, and particularly for health NGOs working with poor people. In 2002, FPHC achieved more than 20% income from its own resources, but obtaining sufficient funds remained a time-consuming exercise for FPHC management, who feel their expertise might be more appropriately channelled to directly health-oriented work. Annual Report 2003: 4 notes a bank policy of reducing interest, which has affected

ARC's income for that year. The most recent communication from Director FPHC notes anxieties about funding from Austria..

In spite of some persistent worries, mostly of a familiar kind, the impression from the Annual Reports and from personal communications is that FPHC remains optimistic and energetic about solutions to problems.

Annex 5

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